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UNTRANSLATED FREUD

(7) TWO ENCYCLOPÆDIA ARTICLES (1922)

[*** *The occasional publication of didactic papers of a more or less elementary kind was part of the programme announced in the very first issue of this* JOURNAL. *The following two articles by Freud, now translated for the first time into English, may be regarded as falling under that heading. Freud wrote quite a number of semi-popular summaries of his views at various periods of his life. The present articles were designed for Max Marcuse's* Handwörterbuch für Sexualwissenschaft, *which was first published in* 1923, *and were reprinted in* Gesammelte Schriften, XI, 201–223. *They were actually written during the summer of* 1922, *that is to say before Freud's final re-casting of his views upon the topography of the mind in* The Ego and the Id (1923). *But the new views, though unexpressed in these articles, must already have been clearly present in his mind while he was writing them, for it was in September,* 1922, *at the Berlin Psycho-Analytical Congress (which is actually mentioned in one of the articles) that he first made public his newly defined conceptions of ego, super-ego and id.*]

(A) PSYCHO-ANALYSIS

PSYCHO-ANALYSIS is the name (1) of a procedure for the investigation of mental processes which are almost inaccessible in any other way, (2) of a method (based upon that investigation) for the treatment of neurotic disorders and (3) of a collection of psychological information obtained along those lines, which is gradually being accumulated into a new scientific discipline.

HISTORY. The best way of understanding psycho-analysis is still by tracing its origin and development. In 1880 and 1881 Dr. Josef Breuer of Vienna, a well-known physician and experimental physiologist, was occupied in the treatment of a girl who had fallen ill of a severe hysteria while she was nursing her sick father. The clinical picture was made up of motor paralyses, inhibitions and disturbances of consciousness. Following a hint given him by the patient herself, who was a person of great intelligence, he put her into a state of hypnosis and contrived that, by describing to him the moods and thoughts that were uppermost in her mind, she returned on each particular occasion to a normal mental condition. By consistently repeating the same wearisome process, he succeeded in freeing her from all her inhibitions and paralyses, so that in the end he found his trouble rewarded by a great therapeutic success as well as by an unexpected insight into the nature of the puzzling neurosis. Nevertheless Breuer refrained from following his discovery further or from publishing anything about the case until some ten years later, when the personal influence of the present writer (Freud, who had returned to Vienna in 1886 after studying in the school of Charcot) prevailed upon him to take up the subject afresh and embark upon a joint study of it. These two, Breuer and Freud, published a preliminary paper 'On the Psychical Mechanism of Hysterical Phenomena' in 1893, and in 1895 a volume entitled *Studien über Hysterie* (which reached its fourth edition in 1922), in which they described their therapeutic procedure as '*cathartic*'.

CATHARSIS. The investigations which lay at the root of Breuer and Freud's studies led above all to two results, and these have not been shaken by subsequent experience: first, that hysterical symptoms have sense and meaning, being substitutes for normal mental acts; and secondly, that the uncovering of this unknown meaning is accompanied by the removal of the symptoms—so that in this case scientific research and therapeutic effort coincide. The observations were carried out upon a series of patients who were treated in the same manner as Breuer's first patient, that is to say, put into a state of deep hypnosis; and the results seemed brilliant, until later their weak side became evident. The theoretical ideas put forward at that time by Breuer and Freud were influenced by Charcot's theories upon traumatic hysteria and could find support in the findings of his pupil Pierre Janet, which, though they were published earlier than the *Studien*, were in fact subsequent to Breuer's first case. From the very beginning the factor of *emotion* was brought into the foreground: hysterical symptoms, the authors maintained, came into existence when a mental process with a heavy charge of affect was in any way prevented from finding its level along the normal paths leading to consciousness and movement (i.e. from being '*abreacted*'), as a result of which the affect, which was in a sense '*strangulated*', was diverted on to the wrong paths and found its outflow into the somatic innervation (a process named '*conversion*'). The occasions upon which 'pathogenic ideas' of this kind arose were described by Breuer and Freud as '*psychical traumas*', and, since these often dated back to the very remote past, it was possible for the authors to say that hysterics suffered to a large extent from reminiscences (which had not been dealt with). Under the treatment, therefore, '*catharsis*' came about when the path to consciousness was opened and there was a normal discharge of affect. It will be seen that an essential part of this theory was the assumption of the existence of *unconscious* mental processes.

Janet too had made use of unconscious acts in mental life; but, as he insisted in his later polemics against psycho-analysis, to him the phrase was no more than a make-shift expression, '*une manière de parler*', and he intended no new line of thought by it.

In a theoretical section of the *Studien* Breuer brought forward some speculative ideas upon the processes of excitation in the mind. These ideas determined the direction of future lines of thought and even to-day have not received sufficient appreciation. But they brought his contributions to this branch of science to an end, and soon afterwards he withdrew from the common work.

THE TRANSITION TO PSYCHO-ANALYSIS. Contrasts between the views of the two authors had been visible even in the *Studien*. Breuer supposed that the pathogenic ideas produced their traumatic effect because they arose during '*hypnoid states*', in which mental functioning was subject to special limitations. The present writer rejected this explanation and inclined to the belief that an idea became pathogenic if its content was in opposition to the predominant trend of the subject's mental life so that it provoked him into '*defence*'. (Janet had attributed to hysterical patients a constitutional incapacity for holding together the contents of their minds; and it was at this point that his path diverged from that of Breuer and Freud.) Moreover, both of the innovations which led the writer to move away from the cathartic method had already been mentioned in the *Studien*. After Breuer's withdrawal they became the starting-point of fresh developments.

ABANDONMENT OF HYPNOSIS. The first of these innovations was based upon practical experience and led to a change in technique. The second consisted in an advance in the clinical understanding of neuroses. It soon appeared that the therapeutic hopes which had been placed upon cathartic treatment in hypnosis were to some extent unfulfilled. It was true that the disappearance of the symptoms went hand-in-hand with the catharsis, but total success turned out to be entirely dependent upon the patient's relation to the physician and thus resembled the effect of 'suggestion'. If that relation was disturbed, all the symptoms reappeared, just as though they had never been cleared up. In addition to this, the small number of people who could be put into a deep state of hypnosis involved a very considerable limitation, from the medical standpoint, of the applicability of the cathartic procedure. For these reasons the present writer decided to give up the use of hypnosis. But at the same time the impressions he had derived from hypnosis afforded him the means of replacing it.

FREE ASSOCIATION. The effect of the hypnotic condition upon the patient had been so greatly to increase his ability to make associations that he was able to find straightaway the path—inaccessible to his conscious reflection—which led from the symptom to the thoughts and memories connected with it. The abandonment of hypnosis seemed to make the situation hopeless, until the writer recalled a remark of Bernheim's to the effect that things that had been experienced in a state of somnambulism were only *apparently* forgotten and that they could be brought into recollection at any time if the physician insisted forcibly enough that the patient knew them. The writer therefore endeavoured to press his *unhypnotized* patients into giving him their associations, so that from the material thus provided he might find the path leading to what had been forgotten or warded off. He noticed later that such pressure was unnecessary and that copious ideas almost always arose in the patient's mind but that they were held back from being communicated and even from becoming conscious by certain objections made by the patient to himself. It was to be expected—though this was still unproved and not until later confirmed by wide experience—that everything that occurred to a patient setting out from a particular starting-point must also stand in an internal connection with it; hence arose the technique of educating the patient to give up the whole of his critical attitude and of making use of the material which was thus brought to light for the purpose of uncovering the connections that were being sought. A strong belief in the strict determination of mental events certainly played a part in the choice of this technique as a substitute for hypnosis.

THE 'FUNDAMENTAL TECHNICAL RULE' of this procedure of 'free association' has from that time on been maintained in psycho-analytic work. The treatment is begun by the patient being required to put himself in the position of an attentive and dispassionate self-observer, merely to read off all the time the surface of his consciousness, on the one hand to make a duty of the most complete candour and on the other not to hold back any idea from communication, even if (1) he feels that it is too disagreeable or if (2) he judges that is it nonsensical or (3) too unimportant or (4) irrelevant to what is being looked for. It is uniformly found that precisely those ideas which provoke these last-mentioned reactions are of particular value in discovering the forgotten material.

PSYCHO-ANALYSIS AS AN INTERPRETATIVE ART. The new technique altered the picture of the treatment so greatly, brought the physician into such a new relation to the patient and produced so many surprising results that it seemed justifiable to distinguish the procedure from the cathartic method by giving it a new name. The present writer gave to this method of treatment, which could now be extended to many other forms of neurotic disorder, the name of *psycho-analysis*. Now, in the first resort, this psycho-

analysis was an art of interpretation and it set itself the task of carrying deeper the first of Breuer's great discoveries—namely, that neurotic symptoms are significant substitutes for other mental acts which have been omitted. It was now a matter of regarding the material produced by the patients' associations as though it hinted at a hidden meaning and of discovering that meaning from it. Experience soon showed that the attitude which the analytical physician could most advantageously adopt was to surrender himself to his own unconscious mental activity, in a state of *easy and impartial attention*, to avoid so far as possible reflection and the construction of conscious expectations, not to try to fix anything that he heard particularly in his memory, and by these means to catch the drift of the patient's unconscious with his own unconscious. It was then found that, except under conditions that were too unfavourable, the patient's associations emerged like allusions, as it were, to one particular theme and that it was only necessary for the physician to go a step further in order to guess the material which was concealed from the patient himself and to be able to communicate it to him. It is true that this work of interpretation was not to be brought under strict rules and left a great deal of play to the physician's tact and skill; but, with impartiality and practice, it was possible as a rule to obtain trustworthy results—that is to say, results which were confirmed by being repeated in similar cases. At a time when so little was known as yet of the unconscious, the structure of the neuroses and the pathological processes underlying them, it was a matter for satisfaction that a technique of this kind should be available, even if it had no better theoretical basis. Moreover it is still employed in analyses at the present day in the same manner, though with a sense of greater assurance and with a better understanding of its limitations.

THE INTERPRETATION OF PARAPRAXES AND CHANCE ACTIONS. It was a triumph for the interpretative art of psycho-analysis when it succeeded in demonstrating that certain common mental acts of normal people, for which no one had hitherto attempted to put forward a psychological explanation, were to be regarded in the same light as the symptoms of neurotics: that is to say, they had a meaning, which was unknown to the subject but which could easily be discovered by analytic means. The phenomena in question were such events as the temporary forgetting of familiar words and names, forgetting to carry out prescribed tasks, everyday slips of the tongue and of the pen, misreadings, losses and mislayings of objects, certain mistakes, instances of apparently accidental self-injury, and finally habitual movements carried out seemingly without intention or in play, tunes hummed 'thoughtlessly', and so on. All of these were shorn of their physiological explanation, if any such had ever been attempted, and were shown to be strictly determined and were revealed as an expression of the subject's suppressed intentions or as a result of a clash between two intentions one of which was permanently or temporarily unconscious. The importance of this contribution to psychology was of many kinds. The range of mental determinism was extended by it in an unforeseen manner; the supposed gulf between normal and pathological mental events was narrowed; in many cases a useful insight was afforded into the play of mental forces that must be suspected to be behind the phenomena. Finally, a class of material was brought to light which is calculated better than any other to stimulate a belief in the existence of unconscious mental acts even in people to whom the hypothesis of something at once mental and unconscious seems strange and even absurd. The study of a person's own parapraxes and chance actions, for which most people have ample opportunities, is even to-day the best preparation for an approach to psycho-analysis. In analytic treatment, the interpretation of parapraxes retains a place as a means of uncovering the unconscious, alongside the immeasurably more important interpretation of associations.

THE INTERPRETATION OF DREAMS. A new approach to the depths of mental life was opened when the technique of free association was applied to dreams, whether one's own or those of patients in analysis. In fact, the greater and better part of what we know of the processes in the unconscious levels of the mind is derived from the interpretation of dreams. Psycho-analysis has restored to dreams the importance which was generally ascribed to them in ancient times, but it treats them differently. It does not rely upon the cleverness of the dream-interpreter but for the most part hands the task over to the dreamer himself by asking him for his associations to the separate elements of the dream. By pursuing these associations further we obtain knowledge of thoughts which correspond entirely to the dream but which can be recognized—up to a certain point—as genuine and completely intelligible portions of waking mentation. Thus the recollected dream emerges as the *manifest dream-content*, in contrast to the *latent dream-thoughts* discovered by interpretation. The process which has transformed the latter into the former, that is to say into 'the dream', and which is undone by the work of interpretation, may be called '*dream-work*'.

We also describe the latent dream-thoughts, on account of their connection with waking life, as '*residues of the day*'. By the operation of the dream-work (to which it would be quite incorrect to ascribe any 'creative' character) the latent dream-thoughts are *condensed* in a remarkable way, they are *distorted* by the *displacement* of psychical intensities, they are arranged with a

view to being *represented in visual pictures;* and, besides all this, before the manifest dream is arrived at, they are submitted to a process of *secondary elaboration* which seeks to give the new product something in the nature of sense and coherence. But, strictly speaking, this last process does not form a part of dream-work.

THE DYNAMIC THEORY OF DREAM-FORMATION. An understanding of the dynamics of dream-formation did not involve any very great difficulties. The motive power for the formation of dreams is not provided by the latent dream-thoughts or day's residues, but by an unconscious impulse, repressed during the day, with which the day's residues have been able to establish contact and which contrives to make a *wish-fulfilment* for itself out of the material of the latent thoughts. Thus every dream is on the one hand the fulfilment of a wish on the part of the unconscious and on the other hand (in so far as it succeeds in guarding the state of sleep against being disturbed) the fulfilment of the normal wish to sleep which set the sleep going. If we disregard the unconscious contribution to the formation of the dream and limit the dream to its latent thoughts, it can represent anything with which waking life has been concerned—a reflection, a warning, a plan, a preparation for the immediate future or, once again, the satisfaction of an unfulfilled wish. The unrecognizability, strangeness and absurdity of the manifest dream are partly the result of the translation of the thoughts into a different, so to say *archaic*, method of expression, but partly the effect of a restrictive, critically disapproving agency in the mind, which does not entirely cease to function during sleep. It is plausible to suppose that the '*dream-censorship*', which we regard as being responsible in the first instance for the distortion of the dream-thoughts into the manifest dream, is a manifestation of the same mental forces which during the day-time had held back or *repressed* the impulse of the unconscious wish.

It has been worth while to enter in some detail into the explanation of dreams, since analytical work has shown that the dynamics of dream-formation are the same as those of symptom-formation. In both cases we find a struggle between two trends, of which one is unconscious and ordinarily repressed and strives towards satisfaction—that is, wish-fulfilment—while the other, belonging probably to the conscious ego, is disapproving and repressive. The outcome of this conflict is a compromise formation (the dream or the symptom) in which both trends have found an incomplete expression. The theoretical importance of this conformity between dreams and symptoms is illuminating. Since dreams are not pathological phenomena, the fact shows that the mental mechanisms which produce the symptoms of illness are equally present in normal mental life, that the same uniform law embraces both the normal and the abnormal and that the findings of research into neurotics or psychotics cannot be without significance for our understanding of the healthy mind.

SYMBOLISM. In the course of investigating the form of expression brought about by dream-work, the surprising fact emerged that certain objects, arrangements and relations are represented, in a sense indirectly, by 'symbols', which are used by the dreamer without his understanding them and to which as a rule he offers no associations. Their translation has to be provided by the analyst, who can himself only discover it empirically, by experimentally fitting it into the context. It was later found that linguistic usage, mythology and folk-lore afford the most ample analogies to dream-symbols. Symbols, which raise the most interesting and hitherto unsolved problems, seem to be a fragment of extremely ancient inherited mental equipment. The use of a common symbolism goes back far beyond the use of a common language.

THE ÆTIOLOGICAL SIGNIFICANCE OF SEXUAL LIFE. The second novelty which emerged after the hypnotic technique had been replaced by free association was of a clinical nature. It was discovered in the course of the prolonged search for the traumatic experiences from which hysterical symptoms appeared to be derived. The more carefully the search was pursued the more extensive seemed to be the network of ætiologically significant impressions, but the further back, too, did they reach into the patient's puberty or childhood. At the same time they assumed a uniform character and eventually it became inevitable to bow before the evidence and recognize that at the root of all symptom-formation there were to be found traumatic experiences from early sexual life. Thus a sexual trauma stepped into the place of an ordinary trauma and the latter was seen to owe its ætiological significance to an associative or symbolic connection with the former, which had preceded it. An investigation of cases of common nervousness (falling into the two classes of *neurasthenia* and *anxiety neurosis*) which was simultaneously undertaken led to the conclusion that these disorders could be traced to contemporary abuses in the patients' sexual lives and could be removed if these were brought to an end. It was thus easy to infer that neuroses in general are an expression of disturbances in sexual life, the so-called *actual-neuroses* being the consequences (by chemical agency) of *contemporary* injuries and the *psycho-neuroses* the consequences (by psychical modification) of *bygone* injuries to a biological function which had hitherto been gravely neglected by science. None of the theses of psycho-analysis has met with such tenacious scepticism or such embittered resistance as this assertion of the preponderating ætiological significance of sexual life in the neuroses. It should, however, be expressly

remarked that, in its development up to the present day, psycho-analysis has found no reason to retreat from this opinion.

INFANTILE SEXUALITY. As a result of its ætiological researches, psycho-analysis found itself in the position of dealing with a subject the very existence of which had scarcely been suspected previously. Science had become accustomed to consider sexual life as beginning with puberty and regarded manifestations of sexuality in children as rare signs of abnormal precocity and degeneracy. But now psycho-analysis revealed a wealth of phenomena, remarkable yet of regular occurrence, which made it necessary to date back the beginning of the sexual function in children almost to the commencement of extra-uterine existence; and it was asked with astonishment how all this could have come to be overlooked. The first glimpses of sexuality in children had indeed been obtained through the analytic examination of adults and were consequently saddled with all the doubts and sources of error that could be attributed to such a belated retrospect; but subsequently (from 1908 onwards) a beginning was made with the analysis of children themselves and with the unembarrassed observation of their behaviour, and in this way direct confirmation was reached for the whole factual basis of the new view.

Sexuality in children showed a different picture in many respects from that in adults, and, surprisingly enough, it exhibited numerous traces of what, in adults, were condemned as '*perversions*'. It became necessary to enlarge the concept of what was sexual, till it covered more than the impulsion towards the union of the two sexes in the sexual act or towards provoking particular pleasurable sensations in the genitals. But this enlargement was rewarded by the new possibility of grasping infantile, normal and perverse sexual life as a single whole.

The analytic researches carried out by the writer fell, to begin with, into the error of greatly overestimating the importance of *seduction* as a source of sexual manifestations in children and as a root for the formation of neurotic symptoms. This misapprehension was corrected when it became possible to appreciate the extraordinarily large part played in the mental life of neurotics by the activities of *phantasy*, which clearly carried more weight in neurosis than did the external world. Behind these phantasies there came to light the material which allows us to draw the picture which follows of the development of the sexual function.

THE DEVELOPMENT OF THE LIBIDO. The sexual instinct, the dynamic manifestation of which in mental life we shall call '*libido*', is made up of component instincts into which it may once more break up and which are only gradually united into well-defined organizations. The sources of these component instincts are the organs of the body and in particular certain specially marked *erotogenic zones*; but contributions are made to libido from every important functional process in the body. At first the individual component instincts strive for satisfaction independently of one another, but in the course of development they become more and more convergent and concentrated. The first (pre-genital) stage of organization to be discerned is the *oral* one, in which —in conformity with the suckling's predominant interest—the oral zone plays the leading part. This is followed by the *sadistic-anal* organization, in which the *anal* zone and the component instinct of *sadism* are particularly prominent; at this stage the difference between the sexes is represented by the contrast between active and passive. The third and final stage of organization is that in which the majority of the component instincts converge under the *primacy of the genital zones*. As a rule this development is passed through swiftly and unobtrusively; but some individual portions of the instincts remain behind at the prodromal stages of the process and thus give rise to *fixations* of libido, which are important as constituting predispositions for subsequent irruptions of repressed impulses and which stand in a definite relation to the later development of neuroses and perversions. (See the article upon the Libido Theory.)

THE PROCESS OF FINDING AN OBJECT AND THE ŒDIPUS COMPLEX. In the first instance the oral component instinct finds satisfaction '*anaclitically*'—on the basis of the satiation of the desire for nourishment; and its object is the mother's breast. It then detaches itself, becomes independent and at the same time *auto-erotic*, that is, it finds an object in the child's own body. Others of the component instincts also start by being auto-erotic and are not until later diverted on to an external object. It is a particularly important fact that the component instincts belonging to the genital zone habitually pass through a period of intense auto-erotic satisfaction. The component instincts are not all equally serviceable in the final genital organization of libido; some of them (for instance, the anal components) are consequently left aside and suppressed, or undergo complicated transformations.

In the very earliest years of childhood (approximately between the ages of two and five) a convergence of the sexual impulses occurs of which, in the case of boys, the object is the mother. This choice of an object, in conjunction with a corresponding attitude of rivalry and hostility towards the father, provides the content of what is known as the *Œdipus complex*, which in every human being is of the greatest importance in determining the final shape of his erotic life. It has been found to be characteristic of a normal individual that he has learnt how to master his Œdipus complex, whereas the neurotic subject remains involved in it.

THE DICHRONOUS ONSET OF SEXUAL DEVELOPMENT. Towards the end of the fifth year this early period of sexual life normally comes to an end. It is succeeded by a period of more or less complete *latency*, during which ethical restraints are built up, to act as defences against the desires of the Œdipus complex. In the subsequent period of *puberty*, the Œdipus complex is revivified in the unconscious and embarks upon further modifications. It is only at puberty that the sexual instincts develop to their full intensity; but the direction of that development, as well as all the predispositions for it, have already been determined by the early expansion of sexuality during childhood which preceded it. This dichronous development of the sexual function—in two stages, interrupted by the latency period—appears to be a biological peculiarity of the human species and to involve the conditioning factor for the origin of neuroses.

THE THEORY OF REPRESSION. These theoretical considerations, taken together with the immediate impressions derived from analytic work, lead to a view of the neuroses which may be described in the roughest outline as follows. The neuroses are the expression of conflicts between the ego and such of the sexual impulses as seem to the ego incompatible with its integrity or with its ethical standards. Since these impulses are not *ego-syntonic*, the ego has repressed them, that is to say, it has withdrawn its interest from them and has shut them off from becoming conscious as well as from obtaining satisfaction by motor discharge. If in the course of analytic work one attempts to make these repressed impulses conscious, one becomes aware of the *repressive* forces in the form of *resistance*. But the achievement of repression fails particularly easily in the case of the sexual instincts. Their dammed-up libido finds other ways out from the unconscious: for it *regresses* to earlier phases of development and earlier attitudes towards objects, and, at weak points in the libidinal development where there are infantile fixations, it breaks through into consciousness and obtains discharge. What results is a *symptom* and consequently in its essence a substitutive sexual satisfaction. Nevertheless the symptom cannot entirely escape from the repressive forces of the ego and must therefore submit to modifications and displacements—exactly as happens with dreams—by means of which its characteristic of being a sexual satisfaction becomes unrecognizable. Thus symptoms are in the nature of *compromise-formations* between the repressed sexual instincts and the repressive ego-instincts; they represent a wish-fulfilment for both partners to the conflict simultaneously, but one which is incomplete for each of them. This is quite strictly true of the symptoms of hysteria, while in the symptoms of obsessional neurosis there is often a stronger emphasis upon the side of the repressive function owing to the erection of reaction-formations, which are assurances against sexual satisfaction.

TRANSFERENCE. If further proof were needed of the truth that the motive forces behind the formation of neurotic symptoms are of a sexual nature, it would be found in the fact that in the course of analytic treatment a special emotional relation is regularly formed between the patient and the physician. This goes far beyond rational limits. It varies between the most affectionate devotion and the most obstinate enmity and derives all of its characteristics from earlier emotional love-attitudes of the patient's which have become unconscious. This *transference* alike in its positive and in its negative form is used as a weapon by the resistance; but in the hands of the physician it becomes the most powerful therapeutic instrument and it plays a part that can scarcely be overestimated in the dynamics of the process of cure.

THE CORNER-STONES OF PSYCHO-ANALYTICAL THEORY. The assumption that there are unconscious mental processes, the recognition of the theory of resistance and repression, the appreciation of the importance of sexuality and of the Œdipus complex—these constitute the principal subject-matter of psycho-analysis and the foundations of its theory. No one who cannot accept them all should count himself a psycho-analyst.

LATER HISTORY OF PSYCHO-ANALYSIS. Psycho-analysis was carried approximately thus far by the work of the writer of this article, who for more than ten years was its sole representative. In 1906 the Swiss psychiatrists Bleuler and C. G. Jung began to play a lively part in analysis; in 1907 a first conference of its supporters took place at Salzburg; and the young science soon found itself the centre of interest both among psychiatrists and laymen. Its reception in Germany, with her morbid craving for authority, was not precisely to the credit of German science and moved even so cool a partisan as Bleuler to an energetic protest. Yet no condemnation or dismissal at official congresses served to hold up the internal growth or external expansion of psycho-analysis. In the course of the next ten years it extended far beyond the frontiers of Europe and became especially popular in the United States of America, and this was due in no small degree to the advocacy and collaboration of Putnam (Boston), Ernest Jones (Toronto; later London), Flournoy (Geneva), Ferenczi (Budapest), Abraham (Berlin) and many others besides. The anathema which was imposed upon psycho-analysis led its supporters to combine in an international organization which in the present year (1922) is holding its eighth private Congress in Berlin and now includes local groups in Vienna, Budapest, Berlin, Holland, Zurich, London, New York, Calcutta and Moscow. This development was not interrupted even by the

Great War. In 1918–19 Dr. Anton v. Freund of Budapest founded the Internationale Psychoanalytische Verlag, which publishes journals and books concerned with psycho-analysis, and in 1920 Dr. M. Eitingon opened in Berlin the first psychoanalytical clinic for the treatment of neurotics without private means. Translations of the writer's principal works, which are now in preparation, into French, Italian and Spanish, testify to a growing interest in psycho-analysis in the Latin world as well. Between 1911 and 1913 two movements of divergence from psycho-analysis took place, evidently with the object of mitigating its repellent features. One of these (sponsored by C. G. Jung), in an endeavour to conform to ethical standards, divested the Œdipus complex of its real significance by giving it only a *symbolic* value and in practice neglected the uncovering of the forgotten and, as we may call it, 'prehistoric' period of childhood. The other (originated by Alfred Adler in Vienna) reproduced many factors from psycho-analysis under other names—repression, for instance, appeared in a sexualized version as the 'masculine protest'. But in other respects it turned away from the unconscious and the sexual instincts, and endeavoured to trace back the development of character and of the neuroses to the 'will to power', which by means of overcompensation strives to check the dangers arising from organic inferiority. Neither of these movements, with their systematic structures, had any permanent influence on psycho-analysis. In the case of Adler's theories it soon became clear that they had very little in common with psychoanalysis, which they were designed to replace.

MORE RECENT ADVANCES IN PSYCHO-ANALYSIS. Since psycho-analysis has become the field of work for such a large number of observers it has made advances, both in extent and depth; but unfortunately these can receive only the briefest mention in the present article.

NARCISSISM. The most important theoretical advance has certainly been the application of the libido theory to the repressing ego. The ego itself came to be regarded as a reservoir of what was described as narcissistic libido, from which the libidinal cathexes of objects flowed out and into which they could be once more withdrawn. By the help of this conception it became possible to embark upon the analysis of the ego and to make a clinical distinction of the psycho-neuroses into *transference neuroses* and *narcissistic* disorders. In the former the subject has at his disposal a quantity of libido striving to be transferred on to external objects and use is made of this in carrying out analytic treatment; on the other hand, the narcissistic disorders (dementia præcox, paranoia, melancholia) are characterized by a withdrawal of the libido from objects and they are therefore scarcely accessible to analytic therapy. But their therapeutic inaccessibility has not prevented analysis from making the most fruitful beginnings in the deeper study of these illnesses, which are counted among the psychoses.

DEVELOPMENT OF TECHNIQUE. After the analyst's curiosity had, as it were, been gratified by the elaboration of the technique of interpretation, it was inevitable that interest should turn to the problem of discovering the most effective way of influencing the patient. It soon became evident that the physician's immediate task was to assist the patient in getting to know and afterwards in overcoming the resistances which emerged in him during treatment and of which, to begin with, he himself was unaware. And it was found at the same time that the essential part of the process of cure lay in the overcoming of these resistances and that unless this was achieved no permanent mental change could be brought about in the patient. Since the analyst's efforts have in this way been directed upon the patient's resistance, analytic technique has attained a certainty and delicacy rivalling that of surgery. Consequently, everyone is strongly advised against undertaking psycho-analytic treatments without a strict training, and a physician who ventures upon them on the strength of his medical qualification is in no respect better than a layman.

PSYCHO-ANALYSIS AS A THERAPEUTIC PROCEDURE. Psycho-analysis has never set itself up as a panacea and has never claimed to perform miracles. In one of the most difficult spheres of medical activity it is the only possible method of treatment for certain illnesses and for others it is the method which yields the best or the most permanent results—though never without a corresponding expenditure of time and trouble. A physician who is not wholly absorbed in the work of giving help will find his labours amply repaid by obtaining an unhoped-for insight into the complications of mental life and the interrelations between the mental and the physical. Where at present it cannot offer help but only theoretical understanding, it may perhaps be preparing the way for some later, more direct means of influencing neurotic disorders. Its province is above all the two transference neuroses, hysteria and obsessional neurosis, in which it has contributed to the discovery of their internal structure and operative mechanisms; and, beyond them, all kinds of phobias, inhibitions, deformities of character, sexual perversions and difficulties in erotic life. Some analysts (Jelliffe, Groddeck, Felix Deutsch) have reported too that the analytic treatment of gross organic diseases is not unpromising, since a mental factor not infrequently contributes to the origin and continuance of such illnesses. Since psycho-analysis demands a certain amount of psychical plasticity from its patients, some kind of age-limit must be laid down in their selection; and since it necessitates the devotion of long and intense attention to the individual patient, it

would be uneconomical to squander such expenditure upon completely worthless persons who happen to be neurotic. Experience upon material in clinics can alone show what modifications may be necessary in order to make psycho-analytic treatment accessible to wider strata of the population or to adapt it to weaker intelligences.

COMPARISON BETWEEN PSYCHO-ANALYSIS AND HYPNOTIC AND SUGGESTIVE METHODS. Psycho-analytic procedure differs from all methods making use of suggestion, persuasion, etc., in that it does not seek to suppress by means of authority any mental phenomenon that may occur in the patient. It endeavours to trace the causation of the phenomenon and to remove it by bringing about a permanent modification in the conditions that led to it. In psycho-analysis the suggestive influence which is inevitably exercised by the physician is diverted on to the task assigned to the patient of overcoming his resistances, that is, of carrying forward the curative process. Any danger of falsifying the products of a patient's memory by suggestion can be avoided by prudent handling of the technique; but in general the arousing of resistances is a guarantee against the misleading effects of suggestive influence. It may be laid down that the aim of the treatment is to remove the patient's resistances and to pass his repressions in review and thus to bring about the most far-reaching unification and strengthening of his ego, to enable him to save the mental energy which he is expending upon internal conflicts, to make the best of him that his inherited capacities will allow and so to make him as efficient and as capable of enjoyment as is possible. The removal of the symptoms of the illness is not specifically aimed at, but is achieved as it were as a by-product if the analysis is properly carried through. The analyst respects the patient's individuality and does not seek to remould him in accordance with his own—that is, according to the physician's—personal ideals; he is glad to avoid giving advice and instead to arouse the patient's power of initiative.

ITS RELATION TO PSYCHIATRY. Psychiatry is at present essentially a descriptive and classificatory science whose orientation is still towards the somatic rather than the psychological and which is without the possibility of giving explanations of the phenomena which it observes. Psycho-analysis does not, however, stand in opposition to it, as the almost unanimous behaviour of the psychiatrists might lead one to believe. On the contrary, as a *depth-psychology*, a psychology of those processes in mental life which are withdrawn from consciousness, it is called upon to provide psychiatry with an indispensable groundwork and to free it from its present limitations. We can foresee that the future will give birth to a scientific psychiatry, to which psycho-analysis has served as an introduction.

CRITICISMS AND MISUNDERSTANDINGS OF PSYCHO-ANALYSIS. Most of what is brought up against psycho-analysis, even in scientific works, is based upon insufficient information which in its turn seems to be determined by emotional resistances. Thus it is a mistake to accuse psycho-analysis of 'pansexualism' and to allege that it derives all mental occurrences from sexuality and traces them all back to it. On the contrary, psycho-analysis has from the very first distinguished the sexual instincts from others which it has provisionally termed 'ego-instincts'. It has never dreamt of trying to explain 'everything', and even the neuroses it has traced back not to sexuality alone but to the conflict between the sexual impulses and the ego. In psycho-analysis (unlike the works of C. G. Jung) the term '*libido*' does not mean psychical energy in general but the motive force of the sexual instincts. Some assertions, such as that every dream is the fulfilment of a sexual wish, have never been maintained by it at all. The charge of one-sidedness made against psycho-analysis, which, as *the science of the unconscious mind*, has its own definite and restricted field of work, is as inapplicable as it would be if it were made against chemistry. To believe that psycho-analysis seeks a cure for neurotic disorders by giving a free rein to sexuality is a serious misunderstanding which can only be justified by ignorance. The making conscious of repressed sexual desires in analysis makes it possible, on the contrary, to obtain a mastery over them which the previous repression had been unable to achieve. It can more truly be said that analysis liberates the neurotic from the chains of his sexuality. Moreover, it is quite unscientific to judge analysis according to whether it is calculated to undermine religion, authority and morals; for, like all sciences, it is entirely non-tendentious and has only a single aim—namely to arrive at a consistent view of one portion of reality. Finally, one can only characterize as simple-minded the fear which is sometimes expressed that all the highest goods of humanity, as they are called,—research, art, love, ethical and social sense—will lose their value or their dignity because psycho-analysis is in a position to demonstrate their origin in elementary and animal instinctual impulses.

THE NON-MEDICAL APPLICATIONS AND CORRELATIONS OF PSYCHO-ANALYSIS. Any estimate of psycho-analysis would be incomplete if it failed to make clear that, alone among the medical disciplines, it has the most extensive relations with the mental sciences, and that it is in a position to play a part of the same importance in the studies of religious and cultural history and in the sciences of mythology and literature as it is in psychiatry. This may seem strange when we reflect that originally its only object was the understanding and improvement of neurotic symptoms. But it is easy to indicate the starting-point of the

bridge across to the mental sciences. The analysis of dreams gave us an insight into the unconscious processes of the mind and showed us that the mechanisms which produce pathological symptoms are also operative in the normal mind. Thus psycho-analysis became a *depth-psychology* and capable as such of being applied to the mental sciences, and it was able to answer a good number of questions with which the academic psychology of consciousness was helpless to deal. At quite an early stage problems of human *phylogenesis* arose. It became clear that pathological function was often nothing more than a *regression* to an earlier stage in the development of normal function. C. G. Jung was the first to draw explicit attention to the striking similarity between the disordered phantasies of sufferers from dementia præcox and the myths of primitive peoples ; while the present writer pointed out that the two wishes which combine to form the Œdipus complex coincide precisely with the two principal prohibitions imposed by *totemism* (not to kill the tribal ancestor and not to marry any woman belonging to one's own clan) and drew far-reaching conclusions from this fact. The significance of the Œdipus complex began to grow to gigantic proportions and it looked as though social order, morals, justice and religion had arisen together in the primæval ages of mankind as a reaction-formation against the Œdipus complex. Otto Rank threw a brilliant light upon mythology and the history of literature by the application of psycho-analytical views, as did Theodor Reik upon the history of morals and religions, while Dr. Pfister, of Zurich, aroused the interest of religious and secular teachers and demonstrated the importance of the psycho-analytical standpoint for education. Further discussion of these applications of psycho-analysis would be out of place here, and it is enough to say that the limits of their influence are not yet in sight.

PSYCHO-ANALYSIS AN EMPIRICAL SCIENCE. Psycho-analysis is not, like philosophies, a system starting out from a few sharply defined fundamental concepts, seeking to grasp the whole universe with the help of these and, once it is completed, having no room for fresh discoveries or better understanding. On the contrary, it keeps close to the facts in its field of study, seeks to solve the immediate problems of observation, gropes its way forward by the help of experience, is always incomplete and always ready to correct or modify its theories. There is no incongruity (any more than in the case of physics or chemistry) if its initial concepts lack clarity and if its postulates are provisional ; it leaves their more precise definition to the results of future work.

(B) THE LIBIDO THEORY

LIBIDO is a term used in the theory of the instincts for describing the dynamic manifestation of sexuality. It was already used in this sense by Moll in his *Untersuchungen über die Libido sexualis* (1898) and was introduced into psycho-analysis by the present writer. What follows is limited to a description of the developments which the theory of instincts has passed through in psycho-analysis —developments which are still proceeding.

CONTRAST BETWEEN SEXUAL INSTINCTS AND EGO-INSTINCTS. Psycho-analysis early became aware that all mental occurrences must be regarded as built upon a basis of the interplay of the forces of the elementary instincts. This, however, led to a difficult predicament, since psychology included no theory of the instincts. No one could say what an instinct really was, the question was left entirely to individual caprice, and every psychologist was in the habit of postulating any instincts in any number that he chose. The first sphere of phenomena to be studied by psycho-analysis comprised what are known as the transference neuroses (hysteria and obsessional neurosis). It was found that their symptoms came about by sexual instinctual impulses being rejected (repressed) by the subject's personality (his ego) and then finding expression by circuitous paths through the unconscious. These facts could be met by drawing a contrast between the sexual instincts and ego-instincts (*instincts of self-preservation*), which was in line with the popular saying that hunger and love are what make the world go round : libido was the manifestation of the force of love in the same sense as was hunger of the self-preservative instinct. The nature of the ego-instincts remained for the time being undefined and, like all the other characteristics of the ego, inaccessible to analysis. There was no means of deciding whether, and if so what, qualitative differences were to be assumed to exist between the two classes of instincts.

PRIMAL LIBIDO. C. G. Jung attempted to resolve this obscurity along speculative lines by assuming that there was only a single primal libido which could be either sexualized or desexualized and which therefore coincided in its essence with mental energy in general. This innovation was methodologically disputable, caused a great deal of confusion, reduced the term ' libido ' to the level of a superfluous synonym and was still confronted in practice with the necessity for distinguishing between sexual and asexual libido. The difference between the sexual instincts and instincts with other aims was not to be got rid of by means of a new definition.

SUBLIMATION. A studious examination of the sexual impulses, which were accessible only to psycho-analysis, had meanwhile led to some remarkable separate findings. What is described as the sexual instinct turns out to be of a highly composite nature and is liable to disintegrate once more into its component instincts. Each com-

ponent instinct is unalterably characterized by its *source*, that is, by the region or zone of the body from which its excitation is derived. Each has furthermore as distinguishable features an *object* and an *aim*. The aim is always discharge accompanied by gratification, but it is capable of being changed from activity to passivity. The object is less closely attached to the instinct than was at first supposed; it is easily exchanged for another one, and, moreover, an instinct which had an external object can be turned round towards the subject's own self. The separate instincts can either remain independent of one another or—in what is still an inexplicable manner—can be combined and merged into one another to perform work in common. They are also able to replace one another and to transfer their libidinal cathexis to one another, so that the satisfaction of one instinct can take the place of the satisfaction of others. The most important vicissitude which an instinct can undergo seems to be *sublimation*; here both object and aim are changed, so that what was originally a sexual instinct finds satisfaction in some achievement which is no longer sexual but has a higher social or ethical valuation. All these are features which do not as yet unite into any whole picture.

NARCISSISM. A decisive advance was made when the analysis of dementia præcox and other psychotic disorders was ventured upon and thus the examination of the ego itself was begun, which had so far been known only as the agency of repression and opposition. It was found that the pathogenic process in dementia præcox is the withdrawal of the libido from objects and its introduction into the ego, while the clamorous symptoms of the disease arise from the vain struggles of the libido to find a pathway back to objects. It thus turned out to be possible for object-libido to change into cathexis of the ego and *vice versâ*. Further reflection showed that this process must be presumed to occur on the largest scale and that the ego is to be regarded as a great reservoir of libido from which libido is sent out to objects and which is always ready to absorb libido flowing back from objects. Thus the instincts of self-preservation were also of a libidinal nature: they were sexual instincts which, instead of external objects, had taken the subject's own ego as an object. Clinical experience had made us familiar with people who behaved in a striking fashion as though they were in love with themselves and this perversion had been given the name of *narcissism*. The libido of the self-preservative instincts was now described as *narcissistic libido* and it was recognized that a high degree of this self-love constituted the primary and normal state of things. The earlier formula laid down for the transference neuroses consequently required to be modified, though not corrected. It was better, instead of speaking of a conflict between sexual instincts and ego-instincts, to speak of a conflict between object-libido and ego-libido, or, since the nature of these instincts was the same, between the object-cathexes and the ego.

APPARENT APPROACH TO JUNG'S VIEWS. It thus appeared as though the slow process of psycho-analytic research was following in the steps of Jung's speculation about a primal libido, especially because the transformation of object-libido into narcissism necessarily carried along with it a certain degree of desexualization, or abandonment of the special sexual aims. Nevertheless it had to be borne in mind that the fact that the self-preservative instincts of the ego were recognized as libidinal did not necessarily prove that there are no other instincts operating in the ego.

THE HERD INSTINCT. It has been maintained in many quarters that there is a special, innate and not further analysable 'herd instinct', which determines the social behaviour of human beings and impels the individuals to come together into larger communities. Psycho-analysis finds itself in contradiction to this view. Even if the social instinct is innate, it may without any difficulty be traced back to what were originally libidinal object-cathexes and may have developed in the childhood of the individual as a reaction-formation against hostile attitudes of rivalry. It is based upon a peculiar kind of identification with other people.

AIM-INHIBITED SEXUAL IMPULSES. The social instincts belong to a class of instinctual impulses which need not be described as sublimated, though they are closely related to these. They have not abandoned their directly sexual aims, but they are held back by internal resistances from attaining them; they rest content with certain approximations to satisfaction, and for that very reason lead to especially firm and permanent attachments between human beings. To this class belong in particular the affectionate relations between parents and children, which were originally fully sexual, feelings of friendship, and the emotional ties in marriage which had their origin in sexual attraction.

RECOGNITION OF TWO CLASSES OF INSTINCTS IN MENTAL LIFE. Though psycho-analysis endeavours as a rule to develop its theories as independently as possible from those of other sciences, it is nevertheless obliged to seek a basis for the theory of instincts in biology. On the ground of a far-reaching consideration of the processes which go to make up life and which lead to death, it becomes probable that we should recognize the existence of two classes of instincts, corresponding to the contrary processes of construction and dissolution in the organism. On this view, the one set of instincts, which work essentially in silence, would be those which follow the aim of leading the living creature to death and therefore

deserve to be called the '*death instincts*'; these would be directed outwards as the result of the working together of numbers of cellular elementary organisms, and would manifest themselves as *destructive* or *aggressive* impulses. The other set of instincts would be those which are better known to us in analysis, the libidinal sexual or life instincts, which are best comprised under the name of *Eros;* their purpose would be to form living substance into ever greater unities, so that life may be prolonged and brought to higher development. The erotic instincts and the death instincts would be present in living beings in regular mixtures or fusions; but de-fusions would also be liable to occur. Life would consist in the manifestations of the conflict or interaction between the two classes of instincts; death would mean for the individual the victory of the destructive instincts, but reproduction would mean for him the victory of Eros.

THE NATURE OF THE INSTINCTS. This view would enable us to characterize instincts as tendencies inherent in living substance towards re-establishing a former state of things: that is to say, they are historically determined and of a conservative nature and, as it were, the expression of an inertia or elasticity present in what is organic. Both classes of instincts, Eros as well as the death instinct, would have been in operation and working against each other from the first origin of life.

ORIGINAL PAPERS

'INTERNAL OBJECTS' AND THEORY[1]

By MARJORIE BRIERLEY, READING

During the last few years 'internal objects' have become increasingly controversial issues. Opinions about them range from over-valuation to under-valuation, even to repudiation as 'not analysis'. This in itself is ample evidence that we are not yet able to see Melanie Klein's contributions on this subject in true or stable perspective. One of the major tasks before the Society is the clarification and scientific assessment of these views.

The first necessity is to arrive at clear statements, in strictly definable terms, of the views that are actually current: misunderstanding is still rife. Moreover, the explanations must be made in terms that permit of their comparison with other views on corresponding matters, e.g. clinical evidence with clinical evidence, theoretical or practical implications with similar or dissimilar theoretical or practical implications. When we are clear what the views are and where and how they differ from other views, then, and only then, can we attempt to assess their scientific status. Assessment will mean consideration from at least three angles. The evidence must be examined for validity and adequacy, and for quality and quantity; the relationship of new views to old must be established; and their actual and potential implications considered. These implications fall into two groups: resultant modification in existing theory, and resultant modification in practice.

Clarity in this field is more easily sought than found. In an earlier note, the writer (1939) pointed out some probable sources of intrinsic difficulty in thinking about 'internal objects'. One of these will bear repetition, namely, that this is a realm in which native or character bias is peculiarly prone to distort the thinker's would-be objectivity. It is, therefore, greatly to be desired that as many Members as possible should report their clinical findings. A wide casting of the net and a big haul of evidence would call for ruthless sorting of the catch, but comparative study and pooling of experience offer some hope of the cancelling out of effects due to individual subjective bias. The production of new theory is always the work of a few minds endowed with creative imagination, but those of us who do not feel ourselves to be gifted in this way still can and should regard ourselves as research workers sharing responsibility for testing and verification.

It is necessary to recognize the inevitability of subjective bias and to devise methods that aim at reducing or neutralizing its effects. But it is just as necessary to ban the public interpretation of any Member's suspected bias as an illegitimate method of argument, a nuisance detrimental to discussion. Such methods do not help to elucidate the facts and it is only the facts themselves and their most probable explanations that we need to establish. In discussing theory, unless we are discussing the subjective motivation of hypotheses as a research problem, we have no concern with the subjective reasons why individuals hold certain points of view but only with the degree of objective validity attaching to the points of view themselves.

We have to work on the assumption that we are all biassed and all tendentious in one way or another. The kind of tendentiousness that can be most usefully exploited in the interests of science is curiosity about facts. Since we are human beings and not science robots, we all have numbers of interests other than fact-finding. But it is immaterial how many motives we have, or how mixed these motives are, so long as they do not take precedence over fact-finding in our scientific

[1] Based on a paper read before the British Psycho-Analytical Society, February 18, 1942, with acknowledgements to Members who took part in the discussion and to correspondents.

work and discussions. Indeed, one indispensable condition for health in a scientific society would appear to be the existence, in a sufficient majority of its members, of the ability to give fact-finding the necessary priority over other motivations. Organization may favour or it may tend to prevent the maintenance of this priority but it cannot of itself create it.

To summarize these general considerations: clear thinking about 'internal objects' appears to be specially prone to subjective interference. We can try to reduce the effects of such interference, (*a*) by co-operative effort, comparative study of clinical findings, and intensive and extensive discussion and testing; (*b*) by individual effort to subordinate all other motives, however legitimate in themselves, to the search for facts, i.e. by maintaining, as steadily as we can, a rigorously scientific attitude.

The next problem is: are there any features in our technical language or in Melanie Klein's presentation of her work hitherto, that impede or do not aid, clear thinking? Ambiguity and confusion are still rampant in our terminology, and Melanie Klein's work does suffer from the general lack of precise definition. In a recent paper, Melitta Schmideberg (1941) considered this source of difficulty in detail. Alix Strachey (1941) pointed out that the word 'internal' is used to mean (1) 'mental', (2) 'imaginary' and (3) 'imagined as being actually inside (the body)'. Hence, we must ask Melanie Klein to which of these types of object she is referring in any given instance. We must be sure that we do understand the exact meaning that Melanie Klein herself intends to convey and not some other meaning.

Confused usage of the word 'internal' is an example of a more general source of ambiguity, our ready tendency to mix our modes of thinking. The bulk of our time is spent in the consulting-room rather than in the study. Hence, we often fail to keep the basic distinction between percepts and concepts constantly present in our minds when we turn from the actual happenings in the consulting-room to their theoretical implications. The work of analysis is carried on almost entirely in terms of perceptual experience. We recognize the necessity of this when we say that theory and theoretical formulations have little or no place in interpretations given to patients. On the whole we are less vividly alive to the corresponding conclusion that perceptual terms have little place in theory. Theory is primarily concerned with generalizations from the particulars of the consulting-room. These particulars are, indeed, our data and also to a great extent our ultimate criteria, but theory itself is a body of concepts and should be expressed in the language of abstraction. Terms such as 'ego' and 'object' have no appropriate place in the consulting-room. What happens there happens in terms of 'I', 'you', 'he', 'she', 'it' and 'they' and is dealt with in these specific and personal terms, the terms in which we lead our ordinary lives. But personal terms have no authentic place in general theory. This distinction in our modes of thinking is not an easy one to maintain and we shall do well to help ourselves to maintain it by avoiding the use of perceptual terms in relation to concepts. The choice of words to serve as technical terms is largely arbitrary and new ones constantly come into use. But where a word is already in use as a technical term it is preferable to use this word in relation to other technical terms rather than a new word with more personal and concrete associations. Thus, it is probably better always to talk about the 'stability of the ego', rather than the 'safety of the ego'. 'Stability' is already in common use as a technical term and can appropriately be used with the technical term 'ego'. 'Safety' is a word which implies that someone is feeling safe, an experience that only a person can have. The phrase 'stability of the ego' is a theoretical translation of the consulting-room experience 'safety of the self'.

The issue involved is more than a matter of words. The phrase 'stability of the ego' is not a mere theoretical translation of the consulting-room experience 'safety of the self'. It is the scientific description of the objective condition obtaining in the mental organization of a person who feels subjectively that his 'self' is 'safe'. Thus James Strachey[1] writes: 'The patient may describe how he feels that he is losing his identity, that his "self" is in danger of falling in pieces or is being attacked by dangerous enemies and that he is worried about its "safety". That's *his* account of what's happening. But what's the *scientific* account? That may very well depend on whether the patient is a hysteric or a schizophrenic. If he is a schizophrenic, the scientific account may be that "the stability of his ego is threatened". But if he is a hysteric, the scientific account may be quite different—for instance, that "the stability of his ego is *not* seriously threatened in spite of his feelings or behaviour". So that a failure to distinguish sharply between the *patient's* language and *scientific* language is not in the least a merely linguistic mistake but may result in capital confusions or errors in our view of the real events.'

This vital distinction between subjective and scientific description of psychological events may also be illustrated by a bodily pain due to a physical stimulus. Thus, if a man with an over-acid stomach eats a sour green apple, he will probably experience pain. He may say about this pain: 'That apple is burning a hole in my stomach.' This, in effect, is a phantasy; the processes set up in his stomach feel like that. The things that are really happening in the stomach will be more accurately inferred

[1] In a letter, quoted by permission.

and described by the physiologist. Confusion between phantasy and objective fact, or, as Alix Strachey (1941) put it, between *figment* of the mind and *function* of the mind, is every whit as disadvantageous to the psycho-analyst as to the physiologist. The advantage the physiologist enjoys over us is that his inferences about gastric function can be verified by more error-proof methods. But this renders it all the more imperative for us to aim at clear thinking about mental function and accurate expression of our ideas.

Melanie Klein (1935), in her account of the 'depressive position' is describing what is, to all intent, an animistic phase of development. It is manifestly unfair, as Joan Riviere once said in discussion, to label as an animist any one engaged in investigating the phenomena of animism. But Melanie Klein's methods of description do sometimes give rise to uneasy doubts as to whether her views are not, in fact, animistic. She is so keenly alive to the child's actual beliefs that she sometimes gives the impression of explaining her theory in terms of these beliefs. Thus, if the term 'ego' is to stand as a concept of a psychic organization it is better to reserve it for this abstract use and not to personify it and use it instead of the child or the self. 'I' and 'self' are the consulting-room equivalents of the study 'ego'. Thus, it is formally correct to say 'the ego has introjected the object' but formally incorrect to say that it can 'feel distressed about it' (Klein, 1935; 153). Again, 'incorporation' is a term which belongs to the child's phantasies of persons and things being literally inside its body, not to an ego mechanism. Phrases like 'the difficulties which the ego experiences when it passes on to the incorporation of whole objects' (*ibid.*, 152) do give a misleading impression. It does not in the least follow that Melanie Klein is an animist; it does follow that her presentation of her ideas does not always safeguard her against this probably faulty conclusion.

The impression has been growing on the writer that one of the major difficulties in coming to grips with Melanie Klein's views is that her generalizations tend to be expressed in perceptual rather than in conceptual terms. She seems to mix the language of phantasy with abstract terminology, and it is perhaps her choice of too concrete words that is responsible for some types of confusion in her hearers. Susan Isaacs[3] says: 'It is Melanie Klein's particular genius that she can and does appreciate the fact that the child's *experience* is in terms of sensation, feeling, perception; that abstract terms are indispensable, but only when they have a real content; otherwise they can serve as screens to hide psychic reality.' Certainly our generalizations should be in the closest possible accord with experience. They should be derived from living experience and continually be referred back to it. But this does not alter the fact that the detailed sequence of a child's actual experiences is something different in kind from any generalization about experience. To take an illustration from geography, the child's experience is the countryside itself, which he and his analyst explore together; theory is only the map. The better the cartographer knows his countryside the more accurate will be the map he makes for the use of walkers. Susan Isaacs is right in objecting to faulty and obscurantist generalizations, they can be fully as misleading as bad maps. But maps are drawn according to certain necessary rules or conventions. The conventions of theory are those of logical, conceptual thinking. The problem for theory is one, as Freud (1933; 107) said, 'of the introduction of the right abstract ideas, and of their application to the raw material of observation so as to bring order and lucidity into it.'

Melanie Klein lays herself open to misunderstanding in her generalizations by a choice of terms too close to her specific source material. Thus, in the expression 'whole object' she uses the word 'whole' to distinguish a person-object from an organ- or part-object. But she also uses the term 'whole' in the sense of undamaged or intact to distinguish it from the object which a child in a certain state of anxiety feels to be in pieces. Now it is quite possible to think of a person being dismembered but it is not possible to conceive of a mental object being literally shattered—one cannot take a hammer to a mental object. But this *impasse* is largely artificial, a consequence of mixed thinking. If the object is consistently thought of as a mental object, a constituent of the ego organization, this stumbling block is removed. It is possible to think of ego systems in terms of integration and disintegration and, indeed, we do so constantly.

The ego system corresponding to the 'whole object' could scarcely be a very simple one, but would itself be a synthesis. As libido is the agent of ego synthesis, it is easy to imagine that the 'whole object' system would be more firmly integrated the more the actual relationship between parent and child evoked a preponderance of libidinal attitudes in both. It is also easy to imagine that integration might fail if the relationship were too ambivalent, or that disintegration might ensue in a phase of severe sadistic tension. The point here is not whether Melanie Klein's views are valid, nor is it suggested that this tentative translation of 'whole object' into terms of ego organization is adequate or correct. What is suggested is that some such translation is desirable and necessary. If we are to put ourselves in a position to estimate the value of Melanie Klein's contribution to theory, e.g. to our concepts of ego development, structure and function, we must get her hypotheses (as distinct from her observations,

[3] In a letter, quoted by permission.

her data) into a form in which they can be thought about in correspondingly abstract terms.

Abstract thought scarcely enters into clinical work as such and it certainly does not make its appearance in infantile phantasy. Melanie Klein has a quite exceptional gift for unearthing the ramifications of phantasy, i.e. for bringing to light material from which theoretical inferences can be drawn. Phantasy is a sort of ticker-tape that records happenings on the mental stock exchange. But the observer has to infer from the figures whether the market is rising or falling, and this inference is, in effect, a generalization from the specific figures recorded. In dealing with theory we have constantly to work from data to generalization and from generalization back to data. We cannot afford to neglect either aspect. Indeed, advance in some sciences has gone hand in hand with increased facility in abstract thinking. Thus, when the physicists first postulated the atomic structure of matter, they conceived atoms as indivisible, minute lumps which combined together to form larger lumps. These ideas have been superseded, largely in consequence of conceptual thought leading to the devising of experiments which ultimately succeeded in splitting the atom. The theory of the structure of matter is now such that it can be described by Bertrand Russell (1931) as 'a wave of probability undulating in nothingness'. The methods of the physicists are at present useless to us, but the conceptual mode of thinking is probably as essential to us as to them. We need not refine our mental objects to nothingness, but we cannot have them lumpy. We must distinguish between living experience and our theoretical inferences about it.

Assuming that we are clear as to what views are actually held about 'internal objects' and have these views expressed in terms that can be used for comparison of data with data, and hypothesis with hypothesis, we can then make some attempt to assess their scientific status. One of the first things to establish is the historical relationship of new views. Tracing the history of the concept 'internal object' through the literature makes it plain that Melanie Klein is no more responsible for the introduction of the concept itself, or the related concepts of 'introjection' and 'projection', than she is for the concepts of 'oral sadism' or 'anal sadism'; and she has never made any such claim.[4] What she *is* responsible for is a detailed elaboration of the rôle and inter-relationships of 'internal objects', especially in early infantile development. We have, therefore, to consider the specific features of this detailed elaboration if we are to arrive at any sound conclusions about the relationship of her work to psycho-analysis as a whole. We must ask, for instance, in what respect and to what extent, if any, do Melanie Klein's hypotheses overstep the limits of consonance with such statements of Freud as: 'Identification with an object that is renounced or lost as a substitute for it, introjection of this object into the ego, is indeed no longer a novelty to us. A process of the kind may sometimes be directly observed in small children.' (1921; 67.) Or, concerning identification with introjected objects: 'At any rate the process, especially in the early phases of development, is a very frequent one, and it points to the conclusion that the character of the ego is a precipitate of abandoned object-cathexes and that it contains a record of past object-choices.' (1923; 36.) Or again, writing of the consequences of accepting a differentiating grade in the ego: 'Let us reflect that the ego now appears in the relation of an object to the ego ideal which has been developed out of it, and that all the interplay between an outer object and the ego as a whole, with which our study of the neuroses has made us acquainted, may possibly be repeated upon this new scene of action inside the ego'. (1921; 103.)

Where differences appear, we need to decide whether these differences are of the nature of contradictions or expansions of pre-existing theory, and whether differences in detail amount to cleavage in basic principles. Any decision arrived at should be based on careful consideration and re-consideration of evidence. Where evidence is insufficient or inconclusive, judgement may have to be suspended, pending the result of further research.

In considering where and how new ideas fit, or fail to fit, into pre-existing theory we need to take into account another kind of perspective—what are the relative proportions of the new and old?—are the old pattern and the new drawn to a common scale?—how does the new addition affect the balance of the whole? Freud himself seemed always to be conscious of the uncharted ocean of ignorance surrounding the solid ground of knowledge that he established. Just because we know so little by comparison with all that yet remains to be known, we tend to be enthusiastic over new knowledge. This is harmless, and even helpful, so long as we keep the new knowledge in proportion and in relation to established knowledge. But it would be a poor geographer who, in his delight at mapping fresh territory, threw away all his other maps. The new map only develops its full value when it is drawn to the same scale and fitted into its right context. Melanie Klein found a way through the 'dim and misty' regions of the infant mind by pursuing a thread of object relationships. To change the metaphor completely, she struck a repaying vein in the gold mine of infantile phantasy, the vein of object relationships. She naturally concentrated on working the vein to the uttermost, and has, in effect, started a gold rush. The yield of ore is rich, though it seems to vary in gold con-

[4] Freud discussed the rôle of introjection in 'Mourning and Melancholia' (1917), and the extensive contributions made by Abraham are summed up in his paper on the development of the libido (1924).

tent and to need more thorough processing before it becomes established currency in theory. But, clearly, there are other veins and other mines. No description of infantile development from one aspect alone can be finally adequate. If every aspect is considered from every possible angle of approach, then we may begin to get something like a complete theory. The risks of concentration on a single aspect or field are the usual risks of over-emphasis, leading to lop-sidedness in the theory pattern.

One way of stating the problem before us is to ask the question: Is a theory of mental development in terms of infantile object relationships compatible with theory in terms of instinct vicissitudes? W. R. D. Fairbairn,[5] whose views are of Kleinian lineage but, nevertheless, his own, and not to be considered as identical with hers, answers this question in the negative. In his opinion, the line of thought initiated by Melanie Klein is incompatible with the classic libido theory. He thinks her views (and his) involve as complete a re-orientation as the supersession of Ptolemaic by Copernican astronomy. For him, it is a case of one or the other: either the libido is essentially object-seeking or it is essentially pleasure-seeking. To the present writer the question savours of a false antithesis and should, in principle, admit of an affirmative answer whether or not current theories are compatible in their present form. The affirmative answer derives from the consideration of the nature of instinct. By Freud's (1933; 125 f.) own most recent definition: 'An instinct may be described as having a source, an object and an aim. The source is a state of excitation within the body, and its aim is to remove that excitation; in the course of its path from its source to the attainment of its aim the instinct becomes operative mentally. . . . The aim can be attained in the subject's own body, but as a rule an external object is introduced, in which the instinct attains its external aim; its internal aim is always a somatic modification which is experienced as satisfaction.' Thus pleasure-seeking is too narrow a description of the aim of instinct. It is just because attainment of the aim of an instinct in relation to a suitable object is felt as pleasurable that we so often describe the process of discharge as gratification or satisfaction. It is, perhaps, unfortunate that Freud shortened his pleasure-unpleasure principle to the pleasure principle. Avoidance of unpleasure is quite as compelling a motive as search for pleasure. The infant, dominated by the pleasure principle, is intolerant of delay in discharge (i.e. unpleasure). Transition to the reality principle implies increase in the capacity for enduring psychic tension (unpleasure) until such time as external (and internal) circumstances permit suitable discharge.

It is, however, indisputable that analysis of the id preceded analysis of the ego. In the first place more emphasis was laid on impulse and aim than on objects, although Abraham (1924; 480 ff.) soon recognized that libidinal development implied parallel development of object-relations. Our current preoccupation with objects may be healthy in as much as it tends to correct the original concentration on impulses. Thus, Freud writes (1933; 126 f.): 'We are . . . still in ignorance about many of the characteristics of the instincts and their history. . . . A great deal of our perplexity also arises from the fact that we have not devoted any attention to the alterations which the instinctual impulses originally belonging to the id undergo under the influence of the organized ego.' Taken in conjunction with the earlier quoted statement that 'the ego is a precipitate of abandoned object-cathexes' we have grounds in Freud's own work for thinking that the object aspect of instinct calls for close scrutiny. But, though the vicissitudes of instinct and the serial story of objects may well repay separate intensive investigation, surely the results of these investigations should be capable of correlation. If they appear to be incompatible, there may be something amiss with one or the other, or both may need some degree of modification. The complete story must take account of impulse, object, and relevant affects. With this amplification, the writer thinks that what she said in 1934 is still true, namely: 'It is evident that we can no longer study development in terms of a theory of impulses alone. We must at every stage be prepared to take into account the type of ego organization through which they operate and the mechanisms by which they are controlled, including the degree of ego differentiation and of reality-sense development which obtains. That is to say the theory of development in terms of libidinal stages has to be expanded into a theory of developmental stages of the whole psyche.'

The relationship of current object theories to psycho-analysis as a whole is a matter calling for prolonged and detailed investigation, and for co-operative effort on the part of all working analysts. This communication does no more than draw attention to certain conditions that have a bearing on the problem of assessment. But this question of the scientific status of 'internal objects' is only a special case of a more general problem, namely, our attitude towards any changes in theory. Most scientific societies welcome deep and far-reaching differences of opinion amongst their members because the occurrence of such differences is regarded as a sign of vitality and growth: indeed, uniformity of opinion and progress in science seldom coincide. New ideas meet with varying degrees of opposition but, however severely they may be criticized, if they prove to be substantiated they are eventually absorbed in whole or in part into general theory. The barrage

[5] In a letter, quoted by permission.

of criticism then moves forward to the next oncoming set of new ideas. Psycho-analysts have two main reasons for attaching what may be unduly great importance to relative uniformity in theory. These reasons spring from the circumstance that we have three functions to perform: research, therapy, and training of Candidates. It is in relation to the two latter functions that we hanker after uniformity and standardization and find ourselves in a dilemma if we think current differences may amount to incompatibility. It is, however, very necessary for us to recognize that uniformity easily conduces to stasis and that a static science is dead.

Scientific truth can never be absolute, because hypotheses are formulated in the light of contemporary knowledge. In consequence, as knowledge grows, older hypotheses become inadequate and have to be revised, expanded or re-formulated to contain newer facts. Freud did this himself, time after time, and if psycho-analysis is to continue to develop as a living science this process of re-casting hypotheses and expanding theory must also continue. A parallel is often drawn between Freud and Darwin: the status of both in science is unassailable. But many more facts have come to light since Darwin enunciated his theory of natural selection, and the theory of evolution has been adapted accordingly. We should be prepared, and indeed hope, for similar growth and development in analysis. To expect to conserve the letter of all Freud's statements, as a kind of 'Bible of Psycho-Analysis' is to condemn psycho-analytic enquiry to stasis and, therefore, psycho-analysis as a science to death. Science is a process of continuous adaptation of theory to continually expanding facts. But the main principles established by Freud will probably persist because they do correspond with facts. The name of Freud will persist with the principles, but they will endure not because Freud established them, but because they are rooted in psychological facts.

The criteria of a new hypothesis are: is the hypothesis necessary?—is it a fuller or a better explanation of a certain range of facts?—does it cover more facts?—and so on—*not*—who is the author? New theories are a matter for proof, not partisanship. If we cannot be bound by an Old Testament according to Freud neither can we profit by a Gospel of the Good Object. Our therapeutic and training responsibilities are, indeed, heavy, but they call for courage rather than for timidity in our approach to new ideas and differences of opinion. Above all, they demand that our handling of all differences should be strictly scientific. We shall safeguard therapy and training and do honour to Freud by perpetuating his own attitude towards his work, only in so far as we succeed in putting first our common task and mutual responsibility, the furtherance of the *science* of psycho-analysis.

REFERENCES

ABRAHAM, K. (1924). (*Trans.* 1927.) 'A Short Study of the Development of the Libido', *Selected Papers*, 418–501.

BRIERLEY, M. (1934). 'Present Tendencies in Psycho-Analysis', *Brit. J. med. Psychol.*, **14**, 219.

—— (1939). 'A Prefatory Note on "Internalized Objects" and Depression', *Int. J. Psycho-Anal.*, **20**, 241.

FREUD, S. (1917). (*Trans.* 1925.) 'Mourning and Melancholia', *Collected Papers*, IV, 152.

—— (1921). (*Trans.* 1922.) *Group Psychology and the Analysis of the Ego.*

—— (1923). (*Trans.* 1927.) *The Ego and the Id.*

—— (1933). (*Trans.* 1933.) *New Introductory Lectures on Psycho-Analysis.*

KLEIN, M. (1935). 'A Contribution to the Psychogenesis of Manic-Depressive States', *Int. J. Psycho-Anal.*, **16**, 145.

RUSSELL, B. (1931). *The Scientific Outlook*, 76.

SCHMIDEBERG, M. (1941). '"Introjected Objects": a Terminological Issue or a Clinical Problem?' Paper (not yet published) read before the British Psycho-Analytical Society, Dec. 3, 1941.

STRACHEY, A. (1941). 'A Note on the Use of the Word "Internal"', *Int. J. Psycho-Anal.*, **22**, 37.

A CASE OF MALE HOMOSEXUALITY[1]

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The reasons which lead me to publish this case of homosexuality are its unusual development and structure. As the reader will see for himself, the structure agrees with none of the patterns that have hitherto been put forward. But this is not the only reason for being interested in the psychological structure of the case. Closely connected with that question is another, which has never yet been settled although it is an essential one, namely, the relative importance and significance of the two factors, physical-constitutional and psychological, in the genesis of homosexuality. The present case contributes interesting material in relation to this question as well.

The subject of this case history was a young man of twenty-seven, who presented himself for psycho-analytic treatment on account of psychical impotence. He came to the preliminary interview with his young and beautiful wife. Both complained that throughout the two years of their married life he had proved to be completely impotent, in spite of their good relations and their genuine love for one another. In the course of the

[1] First published in German, *Int. Z. Psychoanal. Imago*, (1941), **26**, 105.

two years they had made many attempts at cure and the man had been having one kind of treatment or another almost the whole time, but without result. The appearance of the patient was completely masculine. He was short, it is true, but strong and sturdy. He worked on the land and was a countryman by origin. Physically he was healthy in every respect.

In the very first session he disclosed his great and oppressive secret, namely, that he was markedly homosexual. He was quite indifferent to women; but men, particularly simple, robust, strong men in top-boots, such as peasants, or the ignorant, dirty fellaheen of Palestine, aroused strong sexual excitement in him, with accompanying erections, even when he merely saw them in the street. He would also often see Arabs or peasants of this kind in dreams and would masturbate with them or carry out some other sexual practice; and these dreams were accompanied by emissions. In waking life too he was often obliged to think of such men and produce various phantasies about them, which were accompanied by strong sexual excitement.

The patient came from a modest, but comfortably-off, *petit-bourgeois* family in the South of Russia. He was the only son and youngest child; besides him, there were only two girls. His mother died when he was scarcely four years old and his only memory of her was the scene of her death. In this he pictured himself as a small boy sitting by her bed. She was lying in bed and holding his hand in hers while she stroked his head and hair with her other hand. His father and older sister were sitting a little way off crying quietly, while he sat by the edge of the bed almost entirely detached from it all and not grasping or understanding what was happening before his eyes. Then his mother suddenly cried out, fell back and lay still. His father and sister wept aloud and said that his mother was dead. It is true that he remembered the whole scene quite clearly, yet he could not recollect feeling either agitation or sorrow; it seemed to him that he remained quite quiet and unconcerned. After this he was taken away from home.

As I have said already, he had no other memories of his mother. He only knew from what he had been told that she suffered from severe tuberculosis. She spent most of her time in hospitals and sanatoriums, coming home occasionally for short periods, when she was mostly in bed. His maternal aunt and his two sisters ran the house and did the work. Besides this, he had a dim memory of his wet-nurse, who lived in the same small town and had a large family with whom he spent most of his time until he was three years old. Strange to say, all he could tell about his father was restricted to the time after his mother's death. His father had a great deal of business outside the town and stayed away from the house for almost the whole of the week, returning home towards the end of the week, usually on a Friday, to stay until the Saturday evening, leaving again early on the Sunday morning. But, as he remembered it, the two days which his father used to spend at home had been days of suffering and terror for him and the other members of the family. His father was a very severe, brutal man, and beat the children mercilessly for the smallest offence, even the grown-up sister. The patient remembered that as a boy of 8 or 9 he had not only been beaten by his father very brutally for some offence, but had even been knocked down and kicked, so that his step-mother had literally to save him.

His anger and hatred against his father were boundless. He could go on telling me for hours about his father's merciless beatings and ill-treatment, his heartlessness and brutality. The patient spent three whole months of the analysis almost entirely in complaints about his hard and unhappy childhood, without a mother's love and tormented by his father. His sole comforter and protector was his sister, eight years older than himself, who, though she suffered as much as he did from his father, was not so helpless.

Nor were things much better for the patient at school. The teacher, who usually treated the children quite kindly, was very strict with him at the special request of his father, and used often to beat him, too, for the slightest faults, while other children went unpunished. But it is worth noting that the patient, notwithstanding, was very fond of the teacher and was one of his best pupils.

The patient's first homosexual memories, too, dated from his school-days. He recalled the fact that one day (when he was 7 or 8) he had practised mutual masturbation with another boy at school. Besides this, he told of many scenes of a sexual kind of which he had been a witness and which he had observed in a way that was characteristic of him. Peasants from the surrounding villages used to come into the town on market-days, and many of them spent the night in their large carts in the streets and market-place. On these evenings erotic scenes, which were not limited to kisses and caresses, used to take place between young men and women in the streets. The boy had watched these scenes with the greatest of interest, and, as he clearly remembered, his interest was directed chiefly towards the men and their penises. He strove to picture to himself what the woman felt and experienced when she felt the man's penis, grasped it with her hand or felt it penetrating her body. The big, coarse, strong farm-hands, with their heavy boots, were at that time the most important object of his sexual curiosity and sexual phantasies.

At the same time, however, heterosexual impulses were not absent either. He recalled that as a seven-year-old-boy he had imitated coitus with a neighbour's child, and had been caught by his

father and terribly punished. On another occasion, when he was ten years old, he was seized by such strong sexual excitement at the sight of an older girl of 14 or 15 in the street, that he suddenly fell on the girl from behind and caught hold of her breasts. The girl screamed and he ran away in terror. Another time he was sent to a shoemaker and when he entered the house found the shoemaker and his wife in bed and, as he thought he remembered it, saw the man's uncovered and erect penis. This scene had stimulated him sexually to a high degree and when he met the woman in the street a short time afterwards, he fell on her from behind in a state of great excitement and caught hold of her breasts. The woman screamed and he ran away.

He was about twelve years old when the revolution in Russia broke out. His sister left home and moved to a large town in South Russia. After some time she arranged for him to join her. There he had to live with an aunt, who, however, had been very reluctant to take him in. He found a job at a wholesale confectioner's, where he had to work hard; and there he came into contact with the drivers who took the goods round to the retailers. They made him acquainted with the sexual life of a big town. The behaviour of the prostitutes which he could observe in the streets greatly excited him sexually. He was particularly excited by observing a middle-aged man accosting a prostitute and disappearing with her into the doorway of a house. But in this case, also, it was primarily his thoughts about the man's part that excited him.

Meanwhile his stay in the town was becoming more and more difficult. His aunt kept him very unwillingly and made this plain to him on every possible occasion. The town was visited by famine; he lost his job and decided to return to his parents' house.

But in the meantime his father had left the original town and had moved to a town in the Ukraine. The fourteen-year-old boy was very ill when he reached his parents' house. He was suffering from typhus. After about two months he recovered sufficiently to leave the house. There was famine and unemployment in the town. In order to manage somehow or other, he got a position, with the help of his sister, as a clerk in the secretariat of the military garrison. He then moved out of the town along with the garrison and was quartered in a village not far away. He lived in a state of continual sexual excitement; he made repeated attempts to approach women but was prevented by strong inhibitions. And when a hospital nurse fell in love with him and pursued him with offers of love, he reacted to it with strong anxiety and in the end gave up his position with the army in order to return once more to his parents.

His father's family made preparations to emigrate to Palestine. At that time this was no light undertaking; indeed it was a dangerous one. It was necessary to smuggle oneself across the frontier into Poland secretly and illegally. The rest of the journey was not much easier and it took months. Having reached Palestine, the patient left his father and went on the land to live in a *kibuz*.

The homosexual phantasies, in which he indulged from childhood onwards and which now accompanied his masturbation, had undergone an outward change in Palestine; in the place of Russian peasants, Arabs now appeared, or rather the simple fellaheen of the Arab village.

Meanwhile he had reached the age of seventeen years. In the *kibuz* he soon developed a friendship with two young men; they all lived together in one room. He fell passionately in love with one of his two companions, but since the object of his love, who was a stranger to all homosexual impulses, did not respond to his extremely timid approaches, the patient had to take the greatest care to hide his secret and passionate love. The situation soon became still more complicated owing to the appearance of a beautiful young girl, with whom the patient also fell in love; she, however, would have nothing to do with him and loved the friend. Soon afterwards the friend married and thus the patient was left deserted and separated from all that he loved, depressed and in despair. In this condition of mind he met his future wife, a beautiful, intelligent and well-educated girl who offered him love, comfort and solace. At first he rejected her and remained cold. After much hesitation he gave in and a genuine feeling towards the girl awoke in him. They were married—and then his impotence manifested itself.

This is my patient's somewhat obscure and contradictory life-history, given in rough outline. Many details have been omitted and, as so often in analysis, it cost many weeks of work before the picture given here was obtained. Weeks then passed in which the patient indulged in abuse of his hated father. He became furious as he described the unkind treatment, the brutal beatings and torments which he had suffered from him. This certainly relieved him, but the analysis gained little from it and there was not much progress: the condition remained unchanged.

To give a picture of this condition I will sum it up briefly as follows. In spite of his outspoken homosexual tendencies, at all periods of his life he had had heterosexual impulses as well, and he had moreover made attempts to approach women. The homosexual tendencies had already appeared when he was 7 or 8, at which age, as has already been mentioned, he had carried out mutual masturbation with a school-friend of his own age, in which he was the seducer and played the active rôle. At this time, however, his luxuriant sexual

phantasies had an interesting characteristic feature: they were not phantasies about sexual activities *à deux* with a youth or man, but a woman was always present too, and the patient always played the part of an onlooker and identified himself with the woman. He tried to imagine the feelings and experiences of the woman, principally when she touched the man's penis. This remained so until puberty, with the onset of which the patient once more stepped out of the situation of onlooker and took up an independent rôle. The man persisted throughout his phantasies, always with the same characteristics—brutal and primitive. And there was another striking fact: the contradiction between the homosexual tendencies of the patient and his burning hatred of his father.

One day a singular memory occurred to the patient. During the long journey, which had been full of hardships, on the flight from Russia to Palestine, the family came one day to a small Polish town and stayed the night at an inn. The place was by no means a first class hotel but was so small that they all had to spend the night together in one room. The patient saw the bed prepared for his parents (that is, for his father and stepmother) with its clean white linen, and was suddenly seized with a strange and powerful excitement which he could not account for at all. Gradually, with the overcoming of strong resistances, memories came of the evening of his father's marriage, when his stepmother came to the house for the first time. At that time, too, a bed had been prepared in the same way in his father's bedroom, with white linen sheets, and this seems to have made a similarly strong impression on the little boy.

There followed a chain of interesting memories relating to the time after his father's marriage. The appearance of his stepmother in the house and in particular the sexual relations between her and his father made a strong impression on the boy, who believed that, owing to his mother's illness, he had not seen anything of the same kind in his early childhood, and it stirred his sexual curiosity to the highest degree, as well as his desire to look, and most particularly his imaginative activities. For hours at a time, with all the strength of his imagination, he visualized the scenes which might be taking place in the bedroom between his father and his new wife, and his phantasy revelled in these sexual thoughts. In consequence he found himself in a state of constant and undiminishing sexual excitement, and at the same time his sexual curiosity turned specially to his stepmother, towards whom he felt attracted both sensually and affectionately. In a certain sense he was successful, at the beginning, in winning her love, and the relations between them were fairly good up to the time when the stepmother's daughter, a girl of the same age as himself, came into the house.

The pathogenic significance of these childhood experiences, which had been completely repressed and only now emerged again in memory, was clear. The phantasies of the peasants in the market, in which a third person, the woman, appeared, were founded on his father's wedding and the appearance of his stepmother—a fact which was established for the first time at this period of the analysis. And there was no difficulty now in showing that it was precisely these experiences and phantasies concerning the relations between his father and stepmother that had led to the development of his sexual interest in the peasants and their wives. It was now quite possible to relate to his father the ideas and phantasies of the brutal primitive, strong man—the peasant. But how are we to link his strong sexual interest in his father, as a sexual object, with his burning hatred of him? It is true that his sensual homosexual relation to his father has remained in the unconscious, while his hatred of him dominated his conscious thoughts and feelings—though indeed it was this supposition which had now to be confirmed or refuted in the analysis.

The working through of this problem brought about a change in the patient. One day he brought an important contribution to the question of why the sight of the beds prepared for his parents had made such a strong impression on him. He remembered that, until the evening on which his stepmother had come to the house for the first time, the patient himself had slept in his father's bedroom and even in the same bed with him; since that evening, however, he had had to sleep alone in the children's bedroom. His stepmother had therefore separated him from his father.

After strong resistances had been overcome, there emerged in the patient, slowly and with hesitation, memories of a very early time, before he was six, when he had been his father's favourite. His father had spoilt him and always brought him home presents, sweets, pretty things and clothes, when he came back from a journey. And at night his father used to take him into bed with him, and on those occasions the patient had often had an opportunity of observing his father's erect penis, and even of playing with it while his father was apparently fast asleep. Then the patient recalled that this erect penis had made a strongly attractive and at the same time frightening impression on him and that he had always made every possible effort, whenever he was with his father, somehow, without being noticed, to touch and feel his penis. Thus he succeeded again and again in sitting on his father's knee or standing between his father's legs and in pressing close against the region of his father's genitals with some part or other of his own body. The relation between father and son retained this character until the evening on which the stepmother came into the house.

After these memories had emerged and been worked through, the patient's homosexual im-

pulses and phantasies disappeared completely and in their place there appeared a marked indifference to men and the penis. When he met his favourite type (the fellaheen) in the street, the patient remained quite indifferent and undisturbed; nor did they excite the activity of his phantasy. But now something remarkable became evident: this visible effect of the treatment had as its result that sexual impulses of every kind disappeared in the patient and an almost complete sexual frigidity and indifference towards his wife too took possession of him. This was a great disappointment to him and was the reverse of what he had hoped for. He had expected that liberation from his homosexual tendency would of itself bring an improvement in and strengthening of his heterosexual relations with his wife.

As a result of this, his relations with his wife now came into the foreground of psycho-analytical interest. There is much to report about these relations, but I must first interpose a comment, which has a certain technical interest and is at the same time indispensable to an understanding of the further description of the case. Freud's recommendation that patients should live in abstinence during treatment is often very difficult to carry out, particularly if the patient is married. On the other hand situations exist, particularly in the case of marital conflicts, sexual disturbances such as impotence, perversions, etc., in which the carrying out of this rule is particularly important and is very beneficial to the course of the analysis. So it was in this case. For external and economic reasons even more than from therapeutic considerations, the patient was obliged to stay at Tel-Aviv, separated from his wife, while she lived elsewhere with her parents. It was only from time to time that he visited her, usually on Saturdays, but even then not every week. And in this way every visit, each meeting with her, acquired a special significance and a special value, both therapeutic and elucidatory.

At the beginning of the relationship it was his wife who had played the active part and had been in love, whereas he had remained more or less indifferent and had had the feeling that she wished to force him to approach her. Once even, he made an attempt to withdraw from her entirely and broke off all contact with her for a few months, but then gave way again on a chance encounter, though with a decided feeling that he was being compelled to do so. Already shortly after their marriage, scenes such as this used to take place between the young couple. He would lie down in bed beside his wife at night but would remain indifferent and cold, and would quickly fall asleep. This would irritate his wife and she would launch out into reproaches, grow angry and even hit him. He would then get out of bed quietly and quite indifferently and lie down somewhere else to go to sleep again. In doing this he would often be aware of hatred of his wife. When he noticed his wife's despair and tears, he would feel sorry for her and begin to comfort her and to fondle her, and strong sexual excitement would overcome him. But coitus never took place, because complete impotence set in when he attempted it. A further characteristic detail occurred to him in this connection: only the upper part of his wife's body, her breasts, or perhaps her buttocks as well, made him feel really sexually excited, while the lower part of her body and the genital region hardly affected him at all.

At the outset of the treatment his visits to his wife were suspended until such time as he should feel a desire to make one. On his first visit the familiar pattern repeated itself. When they met and first saw one another, and throughout the whole of the day, their relations were very happy and affectionate. At night, when they were together in bed, there was complete indifference, at which his wife became furious and which led on her side to tears and complaints and bitter reproaches. To these he reacted first with dull indifference, and then with actual hatred, and eventually left the bed. Then followed remorse and pity on his side, apologies, reconciliation, strong sexual excitement with an erection—and impotence when he attempted coitus. The next evening before he went to bed he felt depression, headache, sensations of cold and trembling in his whole body—a condition the significance of which he somehow vaguely surmised. The same sequence of events was repeated in approximately the same form during his next visits. Once he had the following dream. He came into a room, in which his sister was sitting. She was crying, and complained that she was in love with a young man and wanted to marry him, but that her father would not allow it and beat her because of it. Then the menacing figure of his father appeared. The patient went into the street, where it was thundering and there was a great noise—and suddenly he was given a box on the ear, so hard that he saw stars before his eyes. At the same time he thought: 'that was father.' The first association was that the day before when he was going to bed he had trembled just as he used to in his childhood when his father had threatened to hit him. So his father had forbidden him marriage and sexual life with a woman, just as he had forbidden it to his sister.

I will take this opportunity to underline the remarkable frankness of the patient's dreams, which often seemed like day-dreams or memories and of which I will give one or two further examples

'I met a lot of Arabs in the road and they had a festive look; or it was in an Arab village. I went up to some of them and made sexual advances to each of them in turn. Finally one Arab allowed me to do everything I liked with him. I touched

his genital region with my hand but found no penis; but instead of it, my hand found his anus and I had a strong erection. But he had his clothes on and I sat him on my knee with his bottom against my penis, pressing him hard against me in order to push my penis into his anus and get an emission—but I failed. The dream made a strong impression on me.'

Another dream ran as follows. 'I was going along the street not far from my house and met three or four men; they were Jews and, what is more, devout ones. One of them came up to me and showed me that he was fond of me, and I wanted to go nearer to him too. I became sexually excited, but this soon passed off and the men also disappeared. I then approached our house. I saw a Jew sitting there in a cheerful, festive mood, as though he had been drinking wine. He went into a room with me. Then I found myself in bed with him and he touched my penis with his strongly erect penis and suddenly he had a powerful emission of semen.' To this he added an association: 'That reminds me of an incident when I was about 5, when I experienced exactly the same thing with my father.'

After the visit to his wife which I have described, the patient brought me an important dream which contributed greatly to the elucidation of his marriage-relationship. The dream ran: 'I passed through a great many streets and round corners and over roofs without meeting any Arabs or anyone else. Suddenly I was in a strongly lighted room and saw in front of me a girl of about 12 or 13 in a white dress. I became sexually excited and wanted to go up to her and to put my arms round her. At that moment I saw my father at my side, making a sign to me with his finger, forbidding me to go near the girl and I obeyed him at once. I woke up in a state of great sexual excitement and had a strong erection, and I was obliged to masturbate.'

The first association showed that the girl in the dream was the daughter of the patient's stepmother, who came into the house a few months after his father's marriage.

This girl, who has already been mentioned, had been given a hostile reception by him. He had felt anger and disgust at every chance contact with her, and particularly when he had to sleep in the same bed with her. The reason for this hatred, moreover, seemed quite clear to him: he had a feeling that the girl had stolen his father's love from him, that she was one of the causes of his being treated badly, of the beatings and of his father's hatred of him. In this connection the patient now remembered that he had had the same feelings and thoughts, immediately after his marriage, about his own wife, when they lay beside one another in bed—but with the difference that, in place of his father, he had to think of one of his friends, of some man or other.

The analysis of the last-mentioned dream provided the explanation of his relation to the girl, for it transpired that when his step-sister first came the relation between the children had been a good and affectionate one. They liked playing together and got on quite well with one another. But their games soon took on more and more of a sexual character; they played 'husband and wife', and in this game he embraced the girl, kissed her, touched her genitals and made an attempt at something like coitus. But one day the girl complained to her mother about the patient doing this. He was severely punished and beaten. Incidents of this kind were repeated several times and were always ended by his father administering severe corporal punishment to him. The girl apparently got enjoyment out of seducing the patient into some sort of forbidden activity and then denouncing him, so as to be present while his father beat him. The patient then developed a burning hatred towards the girl but also a feeling of disgust at every contact with her. He recalled a picture of the girl standing naked in front of him, laughing, exciting him in every possible way, stroking her body, showing her breasts and her genitals and turning round before him, making seductive gestures. This excited him sexually and made him want to touch her and catch hold of her, but he did not dare for fear of the denunciation and the beating which would inevitably follow. He remembered feeling strong sexual excitement, as far back as his seventh year, while playing with this girl, accompanied by erections and even by sensations resembling an orgasm, and at that time it was the lower part of the female body and the female genitals which had chiefly excited him.

After the failure with his stepmother's daughter he turned to the girls in the neighbourhood and played the same games with them. But one day his father caught him at it, beat him severely, forbade him to have any contact with girls and threatened that there would be terrible consequences for him if he were ever again caught committing a similar misdemeanour. In the end his fear of his father prevailed and he avoided all contact with girls. Then came the incident with the boy at school and he turned finally to the male object.

We are confronted here with a case of homosexuality, which, in its psychological structure, its development and its final clinical picture, is unlike any of the three familiar types. It is characteristic of this case that it was precisely at the time of the Œdipal phase that the part played by his mother, or anyone else standing for her, was extremely small. At that time, moreover, his relation to his father was very strong and often assumed undisguisedly sensual and sexual forms. The death of his mother made almost no impression on the patient and, consciously, he did not experience it as

a loss. Some attachment to his sister was present, but it was not strongly felt by him. Only in later childhood, after his father's second marriage, did he feel this relationship more intensely. On the other hand it is important to emphasize that precisely during the phallic phase the boy's chief and ardently loved object was his father, and in particular his father's penis. This apparently led to a quite special over-valuation of the male genital. Freud (1922) has already mentioned the significance of this: 'Behind this factor [narcissistic object-choice] there lies concealed another of quite exceptional strength, or perhaps it coincides with it: the high value set upon the male organ and the inability to tolerate its absence in a love-object. Depreciation of women, and aversion from them, even horror of them, are generally derived from the early discovery that women have no penis. We subsequently discovered, as another powerful motive urging towards the homosexual object-choice, regard for the father or fear of him; for the renunciation of women means that all rivalry with him (or with all men who may take his place) is avoided. The two last motives, the clinging to the condition of a penis in the object as well as the retiring in favour of the father, may be ascribed to the castration complex. Attachment to the mother, narcissism, fear of castration—these are the factors (which by the way have nothing specific about them) that we have hitherto found in the psychical ætiology of homosexuality; and on them is superimposed the effect of any seduction bringing about a premature fixation of the libido, as well as the influence of the organic factor favouring the passive rôle in love.'

As this analysis shows, we find here only a few of the ætiological factors of homosexuality brought forward by Freud. The first factor mentioned by him, which is usually the most important one, an attachment to the mother, appears to have been altogether absent. But in its place there was a very strong homosexual attachment to the father, to which the significance of a seduction might also in a sense be attributed. Some unimportant narcissistic character-traits were, it is true, to be observed in the patient, but there can be no question of any outspoken narcissism in his case. But there is another striking feature in the patient's reactions, which possibly stands in a certain relation to narcissism. Twice in his life his love-relations underwent a strong, or one might even say, a complete repression: towards his father and towards his stepmother's daughter. In both cases the same mechanism of repression was at work, namely, the transformation of an affect into its opposite, the transformation of love into hate. As is well known, this mechanism is characteristic of paranoiacs. A person with a wounded narcissism, with feelings of inferiority, usually reacts to a slight, to a disappointment in love or to a rejection, with depression, with an increase in his sense of inferiority and with self-reproach, as we see particularly in the case of melancholia. People with a heightened narcissism, on the other hand, react with delusions of grandeur, as for example in mania; but the paranoiac, over and above this, reacts with an increase in hate. It was striking that in the present patient, in spite of his impotence, almost no feelings of inferiority were to be observed. He regarded his impotence simply as a fact, without really worrying about it. In fact, one often had the impression that he felt a certain satisfaction about his impotence because it protected him from his wife's demands. This behaviour must, however, be attributed chiefly to disdain and contempt for woman as a sexual object, particularly as he had had no occasion to complain of a lack of potency in regard to his more important sexual object, man.

But in this connection there was a further significant fact: the typical expressions of castration-anxiety, which are usually found in connection with impotence, such as anxiety before coitus, fear of failing in coitus, fear of having no erection, fear of the *vagina dentata*, etc., were absent in the patient. Generally speaking, there were almost no anxiety-symptoms at all to be observed in him and none of the typical expressions of castration-anxiety. He certainly talked about his great fear of his father, but this did not develop fully at the typical age, between four and five, but later, when he was about seven, after his father's marriage. By this I do not mean to say that no castration-anxiety at all existed in the patient, but if it was present it was in such a small degree that it is impossible to attribute to it the importance of a decisive ætiological factor. The patient no longer had to fear castration, for he had accepted it and had resigned himself to the female rôle in relation to his father.

It will be gathered from this that, of the triad mentioned by Freud as being factors in the psychical ætiology of male homosexuality—attachment to the mother, narcissism and fear of castration—not one is to be found to the full in my patient. On the other hand, apart from his strong attachment to his father, there is another factor to be found which was emphasized by Freud—regard for the father and fear of him—and lastly the factor of narcissistic overvaluation of the penis, which, however, cannot be included among the ætiological factors proper. And there is yet another thing to be learned from this case: it demonstrates that the importance of the constellation of the Œdipus complex in judging the causes of homosexuality is perhaps greater than might be supposed according to the theories hitherto put forward.

It must further be remarked that his father's marriage and the change in his attitude towards the patient were a severe disappointment to the latter. His reaction to it was a fresh move in the

direction of normal development, that is, towards heterosexuality: he identified himself with his father and tried to carry out sexual games with his stepmother's daughter, and later with other girls as well, and in these games he took the male rôle and made attempts at coitus. But this development too came to grief, in the first place because of his partner's betrayal, and secondly (according to the patient) because of his father's harshness and punishments. The patient attributed this set-back to his great fear of his father; but this must be questioned, since it seems hardly credible that even repeated beatings at the age of 8 or 9 could have such serious results as the diversion of the sexual impulse into homosexuality—particularly since, from what Freud tells us, it appears that avoidance of rivalry with the father is also present in other cases with quite other constellations and under other conditions. It is much more likely that these results should be attributed to his strong attachment to his father, which brought about a condition of psychical subjugation such as was shown by the patient later towards his friend. Nevertheless this attempted move in the direction of normal development had an important consequence, for it was followed once more by an identification with the female object which had been abandoned; a woman appeared in the patient's phantasies with whom he identified himself, so that he experienced her longing for the male organ. This condition continued until after puberty and indicated a repetition from early childhood, when the psychologically motherless boy had assumed the rôle of his mother in relation to his father.

And there is another consideration. How are we to explain the patient's curiously undisguised and open type of dream? I believe that it is to be related to the peculiarity of the mechanism of repression so strikingly employed by him, in which the work of repression was accomplished not so much upon the ideational material as by a change of the affect into its opposite. A weakening of the affect in the dream was then enough to enable only slightly modified repressed material to obtain representation in the manifest content of the dream.

There is the further question of why precisely this mechanism was employed by the patient. In this connection it may be remarked that ordinarily the super-ego should not be able to offer any objection even to an exaggerated love towards the father. In normal development, and in that of neurotics too, the grossly sensual and sexual elements are repressed, while the affectionate current of feeling is retained in consciousness and often even over-emphasized. That this was not the case with our patient was owing essentially to the change in affect on the part of the object, the father. The patient's ego, which had been spoilt by his father's former love, and which had therefore been intensified in its self-esteem, reacted now to his bad treatment by his father with strong hatred, which sought to efface the traces of the former love from his consciousness and recollection. The anticathexes responsible for the carrying out of the process of repression were mobilized not merely by the super-ego but by the ego-contents also; the repression was set in operation not only by the super-ego but by the ego as well—and principally by purely affective forces. This also increased the resistances in the analysis, which were maintained by both departments of the mind alike.

It only remains now to report that the treatment was brought to a successful conclusion and led to the complete recovery of the patient. When it came to an end his wife was in the third month of pregnancy.

It seems appropriate to raise the question whether we may not be dealing here with a case in which the development to homosexuality took place according to the pattern described by Freud (1920) in his paper on a case of female homosexuality. There, disappointment with regard to the love-object of the opposite sex led to its abandonment and to an identification with it, so that a person of the subject's own sex was then made the sexual object. In our case the love-object was from the beginning a person of the subject's own sex. The disappointment then led to a move in the direction of normal development, towards heterosexuality. This development broke down, however, precisely because of the subject's strong attachment or subservience to the original homosexual love-object.

The second pattern for the development of homosexuality, that proposed by Sadger (1909)—normal primary object-choice of the mother, identification with the mother at puberty and narcissistic object-choice of a person of the subject's own sex—fails entirely (as is shown from the case-history) to fit my patient.

The same must be said of the third structural pattern of the possible development of homosexuality, described by Freud (1922): a situation of rivalry between two children of the same sex (brothers), the development of hatred in one of them towards his rival and finally the overcoming of this hatred by a hypercathexis of the homosexual love-relation to the rival.

Nunberg (1936) believes that he has found yet another type of homosexual development. What is typical of these cases, according to Nunberg, lies in the fact that 'the aim of the homosexual represents a compromise—a compromise between aggressive and libidinal impulses.' He believes further 'that aggression plays a part of importance not only in the object-choice of the paranoiac but in homosexuality in general, and is at least to be regarded as characteristic of a certain type of homosexual.' But he goes on: 'Even the aggressive type displays certain masochistic traits *also*, even though these are not always well marked.

We may therefore speak of a sadistic type when sadism predominates; of a masochistic, when masochism predominates and leaves its impress upon the homosexual.' Actually, therefore, *two* new types are proposed by Nunberg—a sadistic homosexual and a masochistic homosexual.

I find it difficult to concur with these arguments of Nunberg's or with the creation of these new types. In the types set up by Freud and Sadger it is a question of a particular direction of the development of sexual object-choice, of a particular structure and organization of the libidinal object-relation. That is the basis of the whole classification. Nunberg now puts forward an entirely new classification, that of the preponderance in the object relation of a single component instinct. But on what principle, we must ask, was the object-choice made in Nunberg's case? The answer is given by Nunberg himself when he writes of his patient: 'He projects his ideal of a handsome, strong, tall man. This ideal he loves, and he searches for it in the external world.' This means, then, that the object-choice in this case was made according to the narcissistic type. ('A person loves . . . what he would like to be.' Freud, 1914.) But Nunberg's patient had taken over this ideal from his mother. We may therefore say that Nunberg's case is an interesting variety of the Sadger type, a variety in which what is chosen as object is not the subject's own ego (which had been loved by his mother) but his mother's ego-ideal.

In the case which I have described, we are concerned with a peculiar situation in the constellation of the Œdipus complex; for, at the time at which object-choice occurred, the parent of the subject's own sex was alone present and had from the very first taken the place of the parent of the opposite sex. The only object-choice which could be brought out by rivalry was therefore, as a result of this constellation, a homosexual one.

About four years after the conclusion of the treatment I visited the place where the patient lives and met him there. He took the opportunity of introducing his three-year-old daughter to me. His wife was again pregnant. In other respects, too, he felt, as he told me, quite normal, free from any kind of disturbance and happy.

REFERENCES

FREUD, S. (1914). (*Trans.* 1925.) 'On Narcissism: an Introduction', *Collected Papers*, IV, 47.

—— (1920). (*Trans.* 1924.) 'The Psychogenesis of a Case of Homosexuality in a Woman', *Collected Papers*, II, 202.

—— (1922). (*Trans.* 1924.) 'Certain Neurotic Mechanisms in Jealousy, Paranoia and Homosexuality', *Collected Papers*, II, 241.

NUNBERG, H. (1936). (*Trans.* 1938.) 'Homosexuality, Magic and Aggression', *Int. J. Psycho-Anal.*, **19**, 1.

SADGER, I. (1909). 'Zur Aetiologie der konträren Sexualempfindung', *Med. Klinik.*

THE THERAPEUTIC TECHNIQUE OF SÁNDOR FERENCZI

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[EDITORIAL NOTE.—*The technical procedure described in this paper differs, as its author makes quite plain, from that recommended by Freud and generally adopted by his pupils. The paper raises in a clear-cut form a number of problems in connection with the therapeutic process—problems concerned, in particular, with the handling of the transference and counter-transference—which are of primary importance: it therefore offers an admirable basis for equally clear-cut criticism, which may in its turn throw a constructive light upon certain obscurities in the theory and practice of the customary technique. We hope to be able in a subsequent issue to publish estimates from various points of view of the precise respects in which the procedure here laid down is to be approved or rejected.*]

That the personality of the worker, irrespective of his profession, determines the quality and extent of his product is generally acknowledged. In order to describe and understand Sándor Ferenczi's contributions to psycho-analytic therapy one must become acquainted with his essential characteristics. Throughout his life we see him a loyal adherent, a devoted friend and an ardent co-worker of Sigmund Freud. His most treasured memories were of the walking trips in Italy and in the Semmering in the early days of psycho-analysis, when together they tested the Professor's latest theories, offering themselves to each other as subjects and mutually stimulating further incursions into the realm of human personality. To this foundation of loyal devotion and deep affection for his master and friend, Ferenczi brought his own personal gifts. Of these, his sensitivity to human suffering and his high degree of imaginative power were outstanding. The latter made him essentially a research worker; and it is primarily in the light of research that we must view his development of therapeutic technique. Wherever his phantasy led him in his wish to relieve suffering, there he must follow. No stone must be left unturned, no path left unexplored. Failure meant only one's own incapacity. Somewhere, somehow, the successful way could be found. Patience, endurance and a constant determination to learn and to increase his skill gave him the power to follow his explorations. How most deeply to touch the kernel of emotional conflict

and most thoroughly to eradicate it, became for him the central problem of his life. A combination of humility and courage, of sympathy and humour, of brilliant imagination and keen sense of reality enabled Ferenczi to define clearly certain elements in the emotional struggle of human beings and, on the basis of these findings, to attempt throughout his life to improve the already well-established technical developments of psycho-analytic therapy.

Bases of Neuroses

In substance, Ferenczi's concepts of the bases of all neuroses did not differ widely from those of Freud. For purely therapeutic purposes, however, he described them as follows. There must have actually occurred in the childhood of the individual, probably very early in his childhood, one of three sets of circumstances: (1) a traumatic experience of great intensity, necessitating immediate repression; (2) a sequence of less intense traumatic experiences, which may or may not be wholly repressed; (3) a constant exposure to the highly emotional reactions, either sadistic or masochistic, of one or more adults, the memory of which is not entirely repressed. That these three types of experiences are inevitably of a sexual nature Ferenczi hesitated to assert. He was, however, convinced of their traumatic character. He also found them existing in different combinations and in differing degrees of emotional intensity.

In reaction to such an experience or experiences, the child must immediately establish an immunity, first negatively by some degree of repression, and then by a positive construction of protective devices which in the end determines, to a large extent, his personality. These devices protect him not only from his threatening external environment but from his own destructive impulses, which he tends to hold at least partially responsible for the traumatic experiences and which also, because of their intensity, threaten to destroy him himself.

These protections or defence mechanisms, initiated because of their self-protective evolutional use, tend automatically to increase out of all proportion to the need for them and to carry along with them an ever growing anxiety, which in turn calls for further defence. This process in a full-blown neurosis is like a mature cancer, in that it threatens to occupy the entire life of the individual, ending finally in the death of the personality.

Bases of Therapeutic Technique

As a means of contending with the self-consuming system which all neuroses represent, Ferenczi formulated certain new therapeutic principles based on the fact that the components of the system were actual parts of the individual's life, of his living experience, of his emotional relation to other living beings. The therapeutic process, therefore, should centre dynamically around the mutual relationship of analyst and patient. Emotions, being the activating properties of living, must form the instrument for the establishment and continuance of the relationship. In that vital situation the analyst's aim is to assist the patient to penetrate through the repressed and distorted experiences of his life to the traumatic occurrence or sequence of occurrences which are at the root of the neurosis; then to aid him to face dramatically the trauma or traumatic series by re-living it emotionally, not in its original setting but as an actual part of the analytic situation. The ultimate benefit of having emotionally re-experienced these early crucial moments of his life in an adult environment in which he is protected by the presence and aid of his devoted analyst lies in the transformation of his fear of the overpowering passions within him into a new valuation of them as powerful assets.

Ferenczi's method of inducing this dynamic train of analytic experiences is based on the following three precepts:

(1) An emotional relationship between analyst and patient must be allowed to form and must be constantly maintained. This is first initiated in the relieving of the patient's anxiety by encouraging discussion of the analyst, discussion of the patient's most patent characteristics and discussion of their mutual relation; and it is continued by maintaining a changing and highly charged situation between them, primarily by the use of dramatic dialogue rather than by the usual passive explanations and interpretations of the teacher-pupil relation. During this dialogue the analyst should, when occasion arises, express his own natural feelings to the patient in response. This serves to draw out a further expression of the patient's feeling. Such dramatic interplay must in no way be artificially induced; nor should any element of insincerity or inappropriateness enter into it. It must arise spontaneously and naturally.

In continuing the drama, all is grist that comes to the mill: such as the analyst's eliciting criticism of his own personality; the attitude of friendly nearness to the patient, which makes unnecessary such artificial precautions as distance from the analytical couch or furniture placed between analyst and patient; and the allowing of such freedom as the acceptance of tokens of the patient's esteem and affection, meeting of analyst and patient outside of the analytic hour, when such a meeting comes about naturally, and any expression of kind friendliness on the analyst's part. The more natural and fearless the relationship on the part of the analyst, the more helpful it is to the patient. All that creates the atmosphere of parent and child being intimately together helps to maintain the dynamic relation that Ferenczi considered necessary.

Once we have mutually established a relationship of trust and confidence, we can safely leave to the patient's unconscious the shedding of the

protective wrappings which shelter the wounded child. That shocked creature in each of us is like a magnet, full of potential power and exerting a tremendous pull towards any form of assistance that sets up a sympathetic vibration. Therefore, not only must we dispel the preliminary clouds of distrust and anxiety, but we must, as fellow humans, accompany our patients through the shedding process.

(2) Constant effort must be made by the analyst to pull the patient's emotional reactions back into the analytic setting, always bringing the analyst into the centre by relating all associations and actions to himself. Although this occasionally creates resistance, it eventually strengthens the patient's belief in the endurance and sincerity of the analyst, and gradually concentrates the entire analytical drama upon this central figure. It seems unnecessary to state that, in centring the patient's attention on the analysis itself, the analyst should give him no encouragement to neglect his outside responsibilities. These are not only extremely important in themselves, but also serve as a control, a scale of reality, against which the patient's reactions within the analysis can be measured. External responsibilities are the real objects, which, when mirrored in the analytic process, tend to show distortion. To be able to calibrate these distorted images against the actual objects themselves is of great benefit.

(3) In order to bring to the surface the critical dramatic moments of the analysis, care must be taken to avoid alleviating the emotional tension. Technical terms, although they may be reassuring to the analyst, break the current between the two individuals. Interpretative explanations also tend to clear the air, interrupting the strain of the situation, and should be sparingly used. They can however, be occasionally thrown into the dialogue, arousing in the patient the feelings which at the actual time of the related experience had been necessarily repressed, and producing in him an increase in the tension of the particular moment. Throughout the treatment an effort is made to stimulate and maintain dramatic tension in proportion to the increasing strength and emotional health of the patient. This is for the purpose of cutting open the road to the deeply hidden cause of sickness, upon the secret existence of which the whole neurotic organization has been built. There is constant empirical proof that the anxiety which increases as the tension mounts is orgastically relieved after the climax and is followed temporarily by a healthy confidence and strength. This condition allows the entrance on to the analytic stage of new material and new anxieties, the latter of which, like the proverbial snowball, again grow disproportionately and inevitably towards a new crisis. Such a continual spiral motion functions like a rotating drill, cutting its way to the centre of the neurotic disturbance, seeking gradually and finally to relieve the dangerous pressure of the hidden passionate impulses.

The Six Stages of Psycho-Analytic Treatment

To simplify the following illustration of Ferenczi's therapeutic technique, it seems best to divide the treatment into six stages. Needless to say, this division is merely diagrammatic. In describing these stages I hope to emphasize successfully the three technical principles already mentioned: that of a constantly maintained and thoroughly studied emotional relationship between analyst and patient; that of a dynamic concentration of the analytic drama upon this relationship and upon the figure of the analyst throughout the entire treatment; and that of the continual heightening of the patient's emotional tension until the original trauma or traumatic sequence shall have been exposed and explored. These principles represent Ferenczi's outstanding contributions to psycho-analytic therapy.

I. *First Stage of Treatment: The patient decides to be analysed.*

The introduction of a suffering person to such an unfamiliar and frighteningly complicated course of therapy as psycho-analysis affords at the outset an opportunity for clearing away some of the most superficial symptoms of anxiety and in proportion for establishing sufficient trust in the analyst to enable the patient to undertake the treatment. Here the analyst's skill is almost entirely intuitive, as too much kindness or too much matter-of-factness may be equally inhibitive. One must be able to see immediately in the mannerisms of the prospective patient the general superficial protections with which he has equipped himself in dealing with a frightening world. And behind these externalized defences one must sense the form of his inner need. At the first interviews the neurotic patient presents to the analyst his central conflict, as in a nutshell. If it is then and there very carefully exposed to him in the words with which he himself, all unaware, has presented it, he is disarmed by the analyst's sensitivity. He has not been able to mislead him by his superficial defences. The analyst seems to speak his own language if he can thus penetrate to the inner difficulty of which the patient himself is as yet unconscious. The analyst's immediate empathy relieves the patient of sufficient anxiety to allow him the confidence necessary to begin treatment.

Example: A young acquaintance of our family had been sent to me by his relatives, who knew of his incapacitating depressions. Although he was himself aware of his wish to be analysed, he could not at first admit to me that he was thinking of such a step, but simply said that he wished to talk to me. We had several talks and I urged him to undertake an analysis, for I liked him, felt that I could help him and hoped that he would come to

me. He said that he would let me know of his decision in a month. Several months went by. A little later I met him in the street. During our greetings he said that he wished to see me very soon. A few weeks later he made an appointment, only to tell me that he had almost decided to go out West on a job, and so start life anew. I could see that, as a protection, he was unconsciously maintaining a kind of bluff and that in testing me he hoped to find some proof of my ability to sense the bluff and thus to help him. I accused him of treating me just as he had treated his various professors, his much older brother and his father: expecting them to assume all responsibility for him and then making them powerless to use it to his advantage. I disarmed him by asserting that he had originally told his story to me in such a way that, if I had any kind thought for him, I should have to urge him to be analysed, thus taking the initial responsibility upon myself. Afraid, however, to trust any show of kindness in me, he had tested me over and over again, always raising my hopes and dashing them, afraid that I should punish him by refusing to analyse him and hoping that I could stand the test. The final proof came when he told me of his plan to go out West. As answer to this last threat he had expected more urging on my part and not a serious summing up of his uncertain behaviour, which summary both frightened him and won him over. Unpleasant as was this discovery of his motives, he was able to understand the significance of the former months of worried uncertainty and to acknowledge that underneath his proving of me was a great wish to trust someone sufficiently to accept her aid. It seemed that he could now have confidence in me because I had seen through his scheme without reproving him.

My exposure of his method of indirect attack made it possible for him to acknowledge his longing for a trusting, affectionate relationship, his fears that such a relationship could not exist for him and his method of defence against recurring disappointment. It was now apparent to me that through our uncovering of his most evident protective mechanism we were at last beginning to build some slight foundation of mutual confidence. This was seen in the young man's emotional relief, his relaxation and his definite plan to begin his analysis at once. The same battle would, of course, be fought over and over again as the analysis progressed, and of this I warned him. That warning in itself was a proof to him that I was willing to be the battleground. It increased his trust and made his superficial defences less necessary.

II. *Second Stage of Treatment: The patient becomes aware of his superficial mannerisms and habits, and discovers that he uses them to protect himself against frightening situations.*

The early part of the treatment consists primarily in continuing what has been so tentatively accomplished in the first interview. By dramatic dialogue and the constant referring back to the analyst and to the analytic situation, an effort is made to break down the defence mechanisms and thereby to bring to light the material of the patient's inner conflict. Ferenczi recognized that the patient resists with all his power the coming to grips with his fears and longings in regard to his analyst. Instead, he attempts to attract the analyst's attention to the world outside and will go to great lengths in order to succeed in this, thereby allaying his own anxiety and falling back into the seeming security of his neurosis. Only by the analyst's tireless insistence on the immediate importance of the analytic relationship can the subject-matter of his anxiety be brought into the open and the anxiety itself be admitted.

Example 1: This was illustrated in a language mannerism of a patient who at an early stage in his analysis discouraged me by constantly discussing very trivial circumstances of his everyday life, expressing little anxiety. Yet he was in analysis because of sexual impotence and inability to form successful social relationships. The analysis seemed to have reached a deadlock, nothing was happening, there was apparently no emotional tension in him. In an attempt to pull him back to the analytic centre and to me, I drew his attention to the fact that he had lately begun to introduce each sentence with the phrase, 'Well, I don't know' and very often threw into the context the phrase 'You know'. He was completely unaware of this habit but soon grew to realize how constantly he used these phrases and that in fact they meant just what they said. He was refusing to know or admit anything and was insisting on my taking the responsibility for all decisions, ideas and feelings which were in reality his own. He would not take the consequences of them. This discovery not only showed him intellectually how afraid he must be of the smallest responsibility but awoke in him an ardent unconscious wish that he were a girl with breasts and no penis. This he expressed with real feeling, begging me to take care of him and not to expect anything of him, to help him get rid of the woman with whom he was then involved and to protect him from further sexual affairs. He then admitted that he had feared that I, like his mother, would consider him incapable of competing with other men. In calling attention to his superficial mannerism I had awakened his anxiety and emotional tension in the present in regard to me.

Such evidences of anxiety should be immediately brought to the patient's notice—to his immediate discomfiture but to his eventual relief. Accompanying the anxious symptoms are the problems themselves, around which the anxiety centres.

These now take the centre of the stage, as will be seen in the next case.

Example 2: This patient greeted me on each of the first few mornings with an open and delightful smile, saying: 'Well, how are *you*?' He then lay down very stiffly, always in the same position in every detail and remained quiet for ten or fifteen minutes. His only action was to moisten his dry lips with his tongue. Finally he spoke of some recent occurrence or thought, using very stilted and intellectualized language, each word carefully chosen, his voice very gentle, and with very little expression of face. He was surprised to hear this description of himself and of the impression he made on me: that of being a very frightened person, whose every move from his beaming smile of greeting to his careful speech and posture was calculated first of all to create a friendly atmosphere and then to keep it friendly, in order to forestall any chance of irritation on my part. Reacting to this description as to an attack, the patient threw out his chin. I drew his attention to this action, asking if I had irritated him. He then stretched his neck and rubbed his collar, and I remarked that he was trying to blame his collar instead of me. At this he blushed and quickly went on to some fresh topic, and I let him go. A little later in the hour he said that he always wore very quiet clothing for fear of criticism from passers-by in the street. This remark, I told him, probably referred to me, as he undoubtedly felt that I had been criticizing him, and wished that I would 'pass him by'. I also said that I realized that such feelings must be difficult for him to acknowledge, adding that there were surely many things about me which he did not like. With difficulty he agreed that he hadn't liked either my noticing his irritation or my personal remarks about his chin and collar, for he knew that he had been angry with me and hadn't wanted me to know it. He also admitted that he had a bad temper and that his father had one, too. He had once been afraid that his father would kill his younger brother.

During the next few days of analysis he spoke often of his growing consciousness of the many mannerisms and habits which he had acquired in order to ensure for himself a non-irritating environment. He had recently asked some of his friends about this and they had said that they also had noticed these characteristics in him. As he became more aware of his superficial anxieties and his need to protect himself from them, he grew more able to admit the underlying anxieties, his childhood fear that his father would, through his cruelty, force his mother to have another child, and finally his fear of his own homosexuality. This latter was a very difficult subject for him to broach. That so much material came, and came with appropriate feeling, during this first week of analysis, was due to his becoming conscious of his anxiety and of his anger through the discussions which I kept centred around himself and me. In this early stage of the treatment such discussions cannot be as dramatic in tone as they later become. But they can be actively directed by the analyst in order to prevent the patient's attention from wandering into paths of emotional escape, and in order to heighten the tension which threatens at every opportunity to decrease. Owing to my stimulation, this patient became more and more anxious in regard to his feelings about me; but, simultaneously with the expression of his fears, he experienced added relief in finding that these personal discussions did not result in any danger to him, but, on the contrary, increased his confidence in me. He had had a chance to learn that my calling his attention to his mannerisms was not an act of hostile criticism, and that in telling me what he did not like about me, he had not been misunderstood and hence punished by me. To have learned to let drop some of his defences, to have dared to speak critically to another person, were to him entirely new and heart-warming experiences. He rewarded me for giving him this slight relief and security by giving me in exchange the present of very difficult and frightening material.

III. *Third Stage of Treatment: The patient learns the emotional causes of his fears through examination of his character traits and through observation of his habits of behaviour, in particular towards the analyst.*

With the disappearance of the more superficial forms of anxiety and protection comes a new stage in the analytic process. The mechanisms that motivate the patient remain the same, but the subject-matter of these mechanisms changes. In place of habits of personal appearance and action we now have to deal with character traits and the more serious problems and results of behaviour.

As we make our way closer and closer into the heart of the patient's neurosis, two dynamic processes seem to be activating the analysis.

(1) The patient is driven to act out much more seriously, and frequently with some degree of danger to himself, his ever-present compulsion to test his environment. This he does in many different disguises. He tests his family, his old friends and new friends. In all this activity outside of the analysis he is, of course, continuing to test his analyst. At such junctures the analyst must, with all his skill, attract the patient's attention and activity again to the analytic situation, the focal point of the therapeutic process. It is, however, unavoidable that new sets of emotional circumstances frequently appear for the first time as actions in the external world. Upon their appearance they should be immediately drawn into the analytic world. In the first interview and subsequently, we have seen this method of attack used in relation to superficial manners and habits. In this third stage, also, the same method

must be applied in dealing with the patient's increasingly active tendencies. Each such occasion has similar ear-marks and from it the analyst, and finally the patient also, learns the essential characteristics of the actual traumatic happenings of his early childhood.

(2) In company with this more courageous and more frightening behaviour, one senses a constant growth in self-confidence, a more healthy appearance and a greater degree of trust in the analyst. As this more healthful side of the picture enlarges, more strength is also seen in the compulsive drive to push the analyst beyond his endurance. The resolution of such stormy conflicts is to some extent due to the analyst's open and sincere expression of his own reactions to the patient. He may be tried and disheartened; he certainly dislikes many of the patient's characteristics. Such feelings the patient expects in the analyst, dreading at the same time lest he has really outraged him. If, after the height of the storm, the analyst admits his discouragement or his irritation or his encouragement or admiration, as the case may be, the patient's fear of destruction is lessened. To find the analyst not far removed from himself in human feelings increases his confidence and tends to assure him of his sympathy. Such a situation is quite different from any relationship that the patient has ever before experienced. To be extremely sullen or angry day after day, to be allowed and encouraged to express that anger, to be received each of these days with constant and respectful care, to be told quite sincerely and clearly but without anger the analyst's reactions to such occurrences, helps greatly to relieve the intense anxiety that has surrounded the patient since his earliest days and gives him the strength to continue the search for its original source. Not only is his anxiety relieved, but, in proportion to its relief, there is initiated a steady capacity to reach out from self-absorption, to sense in himself tender and deepening feelings for a person other than himself.

Example: As an example of this period of the treatment, when observation of the patient's superficial manners changes and becomes concentrated on his actual behaviour, I will describe an hour with a young man who had been in analysis for three months. His first remarks had to do with a dream of the previous night, in which he had visited 'an eye doctor', arriving at the doctor's office forty-five minutes late. In examining his eye the physician rubbed his finger around the eye many times, as the patient himself actually did almost continuously during his analytic hours. Finally the doctor suggested sending the patient to another doctor, whose name was confused in the patient's mind. After exclaiming over this 'senseless dream', the young man told me that at last over the week-end he had succeeded in the hitherto difficult task of enjoying a social evening with friends; but that when they wished him to go with them to a dance the following evening, he had felt that there were many reasons why he could not accept, and afterwards he had realized that they were only pretexts and regretted not accompanying his friends. His room-mates had left him alone the next afternoon and he had taken the occasion to masturbate, but only 'in the spirit of getting it over with'. He had lately been worrying about the problem of finding a job and had decided not to follow my suggestion but to hunt for one at once. I had previously very tentatively suggested that with his strong resistance to accomplishing his college work, it might be informing to see for a while how he would react to no schedule and no job.

Throughout this analytic hour the patient had been restless, dissatisfied and anxious, with perspiring hands. I brought to his attention the fact that these symptoms, together with the restless and unsatisfying activity of the week-end, had been dramatized in the dream, and that in all three forms he was showing his dissatisfaction with me, his 'I-doctor', and was expressing some impulse to find another analyst. He seemed, indeed, to be making a laughing-stock of me and to be telling me that my wish, as he interpreted it, to encourage him to be social, also to masturbate, and to enjoy himself instead of seriously undertaking a job, would lead to utter confusion for him. This interpretation was exceedingly distressing to him; he felt that he was being accused of making a fool of me. I further accused him of attacking me, not directly in angry words, but indirectly in his dream and actions, which showed in dramatic form his complaint of the poor results afforded by my treatment. I told him that it was evident that he must be really greatly irritated with me for trying to upset his life-long compulsive habits. At my words he was torn between his fear of losing these habits, his anger with me for disturbing them and, paradoxically, his relief that someone had at last discovered his destructive wishes, thus making them powerless, and was not deterred by them. Tears came into his eyes and he expressed his severe struggle in saying: 'All I can say is that I don't like you less for what you've just shown me. I don't as yet seem able to admit that I really like you more.'

That I showed him what a potential danger I seemed to him in my guise as his helper, and that I did not blame him for making a fool of me in retaliation, relieved him of some anxiety and hence brought very slight and ambivalent feelings of tenderness to the surface. This analytic hour represented an unconscious attempt on the patient's part to deal with his struggle for independence against his up-bringing. The attempt was dramatized in the emotionalized situation between analyst and patient. In order to maintain this dramatic tension, what interpretations I had made

had not referred in any way to his past experience but were entirely concerned with us and with the situation between us. This was growing more and more acute. He felt intensely his resentment against me for confusing him with my tempting suggestions to lay aside his strict self-discipline and to enjoy himself. He was also frightened at his anger with me. Here there was brought into the analytic experience a duplicate of the frightening relation of father and son. That relationship was now actually re-lived but with a different outcome. To his surprise, this son now found that he would not be harmed if he dared to express both his rebellious feelings against me and his fear of thus expressing them.

Such a slight crisis is an example on a small scale of the ultimate crisis towards which the patient was making his way. It was for him, however, an occurrence of some magnitude; particularly so because, existing in the immediate present and involving a person of increasing value to him, it must be faced and could not be avoided. This was symbolized by a dream in which he stood at the end of a high diving-board trying to find the courage to dive into a pool far below, where other swimmers, who had just dived successfully, were playing a delightful game. He felt that his future security and happiness were at stake. He was caught between his feelings of rebellious anger with me and an increasing need for me.

The opportunity of re-experiencing the disastrous moments of his childhood not only shows the patient, through a highly emotionalized medium, the contents of his unconscious life, but also helps him to realize, through his own immediate and imperative personal struggle with the analyst, that his ingrained fears are no longer insoluble, that in the analysis they can again be felt directly in reaction to an actual situation and this without a destructive result. This relief from anxiety gives rise to the emotional strength to face the next ordeal.

IV. *Fourth Stage of Treatment: The patient admits the hopeless failure of his neurotic protections against anxiety and, as a result, openly attempts a direct struggle against the threat of destruction which the analyst seems to him to represent.*

Through long months of analysis the patient is gradually becoming more and more enmeshed in a maze of his own making. Wherever he turns, whether into contemporary situations outside the analysis or into memories of his childhood, he is constantly confronted with the same causes for anxiety, the same defences against anxiety and the same sterile results of these defences. Here again, Ferenczi's method of active participation on the analyst's part in the emotional turmoil is used to keep the patient constantly aware of the hopelessness and failure of his former methods of protection and escape. He does not know where to turn; and there results a time of great despair. With this despair the emotional tension attains a high level. This the analyst should continually focus on himself. The success of this technique lies, to a great extent, in the fact that the analyst is working in co-operation with the patient's unconscious and therefore, in the patient's eyes, is working against him. This co-operation with the unconscious is a powerful tool and provides the impetus which drives the patient even more intently and angrily towards the very figure whose purpose in his life is to bring him to health. That that figure seems instead to have successfully destroyed even the little that he had so carefully constructed in his neurosis, infuriates him; and he, in turn, is confronted with the impulse to destroy him. Here we see approaching the great conflict of the analysis, the counterpart of the early and equally terrifying original trauma. If health is now to be regained, the analytic struggle must result in the final breaking down of the strong defences against the analyst, in the courageous, direct emotional attack against him and its successful outcome, and in the ultimate discovery that in this victory he becomes a valiant, carefree person in his own right.

Example: A case after several years of analysis may now be in point. This young man had from birth been a continual disappointment to his family and to all his friends. As daughters only were wanted by his parents, he was at birth given over to a governess, remaining always the ugly duckling of the family, while his sister was treated as a beautiful swan. As a result, his life was devoted to proving himself the prey of all about him, particularly in his adulthood the prey of women of his sister's age. This, of course, brought great unhappiness and ruin to others besides himself. His external hardness of manner combined with a hypersensitive show of pride, in which the ugly duckling masqueraded as a man of the world, were at first the prevailing signs of his anxiety. He had developed great skill in apparent self-possession and indifference. Many months of analysis passed before he dared to throw off these protections and could allow himself to feel the despair of being an unloved person. Probably this new courage was due to the fact that, no matter how he acted or how cruel he seemed, I remained faithful and trusting. I could, however, have little affection for such an unlovable person. This I told him. But at least, he was endured; and, more than that, he learned that I was earnestly endeavouring to help him. He found that he could distress me and greatly discourage me, even to the extent of admissions on my part that perhaps, after all, there was no hope of his complete recovery. Yet I stood by him and worked with him sincerely. No one had ever done this much for him before; and gradually he had the courage to lay aside his useless, cruel brittleness and be a

sad, confused, and very lonely child. This very sincerity brought him friends and developed in him a great capacity for loyal devotion. His violent envy and destructive anger towards women slowly eased, as his belief in his own integrity and in his capacity for devotion strengthened. He became too valuable to himself to be any longer a despised duckling.

As he timidly began to discard his defence against the other sex and to try to value women for themselves and for his happiness, instead of as instruments of disaster, an early form of anxiety returned. He became exaggeratedly sensitive to criticism. His old brittleness and sullenness of manner were resumed. This attitude became increasingly directed at me and it seemed probable that, in order to rid himself of his anger against women in general, he was preparing to shift the battle front again to the analysis. This had, of course, occurred at frequent intervals throughout the treatment. On this occasion, however, the emotional set-up had a different ring to it. There was now a hollowness in his reactions to the outside world. By way of the analysis, he was very evidently beginning justifiably to blame his mother, rather than his sister, for his long life of disaster. His emotional strength seemed to me sufficiently great for me to allow him his head, and then to stand by to watch him find his own method of control.

This resulted in my keeping almost entirely silent for a period of many weeks. At the beginning of this period of silence he had early in the hour asked me a question, not from interest in the answer but to avoid a momentary hurt. I had not replied. This had further hurt his pride and he had become sullen. The remainder of the hour was spent in silence on both our parts. His tendency the following day was to overlook this situation between us. In order to keep him centred in the analytic field, I reacted with continued silence to his attempts to change the emotional tone. In so doing I was able to maintain the tension of the previous day. His increasing anxiety then manifested itself in his redoubled sensitivity. His anger became intense, and with it the fear of unloosing it and doing some real damage to me. His only refuge was in maintaining a sullen, passive attitude. At the end of each hour I let him go out of the door without a word from me to relieve the tension. The following two weeks were almost entirely spent in silence, except for the relating of his dreams at the beginning of each hour. These dreams were revealing as evidences of his intense conflict. He had sufficient insight to make it unnecessary for me to assist him in their interpretation. Such an act on my part would have been seized upon by him as a friendly generosity and thus would have immediately relieved the tension between us. Nor did I at this juncture feel generously towards him. The insistent urge at last to express his aggressiveness towards me directly, his terror of the consequences, his lifelong defensive attitude of sullen withdrawal from every irritating situation, his retention of this protection to which he was accustomed, his inability to see any way out of the dilemma—all this struggle is represented in the following dreams, together with a slowly developing determination to work his way through to the finish.

Dreams: (1) 'My sister, S., and I were planning to ride through some woods. The livery-stable man told me that the owner of the woods, Mr. H., didn't like us to ride on the wood roads and might take a shot at us. I saw my sister ride up the road and rode after her to warn her. Mr. H. popped up from behind a bush and shot at S. I rushed at Mr. H. and shook him and scolded him. Afterwards I felt sorry that I'd done it.'

(2a) 'A dreadful nightmare. Somewhere in a house I saw a man. I hit him over the head and ran away like lightning. He chased me and we ran upstairs and down, on and on. I don't know whether he caught me, but I was terrified.'

(2b) 'I was in a room. I think the same man was there and other people. Suddenly out-doors there were terrible explosions. I looked out of the windows. Pieces of pipe, rocks, etc., were flying through the air. I was terribly frightened and concerned, but no one else seemed to pay any attention.'

(3) 'Another nightmare. I was upstairs in some house in bed, alone in the house. I heard a noise, a footstep. I knew someone was in the house and was terribly frightened. But I determined to go downstairs to see what it was. I would never do that in reality, I would just lie quietly under the covers. In the dream I was determined to do it, although I was so scared. I'm sure this dream had to do with my little girl. I had to see what scared me so in order to protect her.'

(4) 'Another boy and I were going up a mountain. We were to come down in a car on a cable. He said he had a better way. He was going to hold on to something which was fastened on the cable. In that way he could see all around him as he came down. It terrified me and I said that I much preferred riding down in the car even though I couldn't see. Yet I knew that I ought to do as he did, that it was a better way. He didn't seem to be at all afraid, but I was horribly scared. All the time that I was dreaming, I knew it had to do with the analysis.'

(5) 'I was driving my car, someone was with me. I think it was my governess. Suddenly in Gramercy Park I came upon three cars that had run into each other, one after the other. There was no way to turn out, no way to avoid them. I just had to run up on them. I was furious. Afterwards everyone tried to comfort me and said that I could have the car repaired, fenders ironed out,

etc. But it did no good to say that. I knew that I could do that ; but the frame was bent and that could never be fixed. It was like the last dream. I knew all the time that I was dreaming, that it was about the analysis and I was my car.'

(6) (This dream seemed to the patient to be 'made to order'.) 'A map was spread out on the floor and I pointed to the places where I had been, and then showed Billy where we would have to fly, across a desert, and told him that in the middle there was a hidden city. You couldn't see it on the map, but I knew it was there. Billy was to pilot the airplane and he said that he wouldn't fly over the desert. He didn't believe that the city was there and besides it was very dangerous over the desert. But I was determined to go. Then we were in the plane above the desert and I saw the city and showed it to him and proved that I was right.'

These dreams had occurred over a period of five weeks, during which time I had maintained an almost complete silence. The patient was in great conflict with himself. I was an onlooker, waiting and ready to prevent him from harming himself or me, if such an impulse arose. He used me during these weeks as material for his struggle ; built up and pulled down many phantasies of my iniquity ; was constantly complaining of my unfriendliness, untrustworthiness, of my variable treatment of him, of my stubborn insistence on having my own way. All of these characteristics were typical of his own mother. He insisted that he would win out against me, even if it should mean his giving up the analytic treatment, and hence not gaining his health. As a final threat, he threatened to kill himself. Many analytic hours were spent by him buried in a blanket, lost in silence. A tremendous struggle was being enacted each day during his hour. Gradually my own endurance was being worn down and I grew aware of my increasing anxiety on his behalf. The day came when I myself could no longer stand the tension. I feared that he could not win the battle. I found that I must confess that he had more power than I ; that I was too weak to stand his constant silent, sullenness as an indirect method of attacking me ; that I was nonplussed and knew no further way of helping him ; that although a future victory over himself was of great moment to me, I was now terribly disheartened. My admissions of defeat, of course, proved to him my affectionate concern and also his superior strength, and for a moment pleased him. Almost immediately, however, he began again to accuse me, this time directly and justifiably. By my confession, by my weakness, I had deprived him of a battlefield. Why hadn't I let him alone, why was I an analyst if I was so weak ? For the rest of the hour he maintained an honest and direct attack on me. During the next week came the following dreams :

(7) 'I dreamed that I was masturbating, but kept being interrupted and I was frantic. I went from place to place, trying to find some place where I could be alone, but I was always interrupted.'

(8) 'A dream about Tommy. I was to go to one small town and he to another. When he arrived, he was to telephone me and I was to drive over to him. I went to my town, and waited and waited. No word ! So I finally went over to his town and there he was, dead drunk. I was furious and raged at him. But I realized that it would do no good, I couldn't change him, so I shut up and went back to my town.'

The following dialogue took place between us as the result of this last dream :

P. 'I know that dream has to do with you and me. First of all, Tommy is you and that's the way I've felt these last six weeks about you. Also in the dream you are me, and I am Tommy. You can't change me, no matter how hard you try. And yet I know there is a point in my changing ; and instead of shutting up, I should really face you when you infuriate me.'

A. 'What could that point be ? '

P. 'Well, I'd be more honest. I would really be expressing my feelings. But I don't dare ! '

A. 'Why not ? '

P. 'If I'd done that with Tommy I'd have lost him.'

A. 'So you think I couldn't stand it ? '

P. 'If I broke your favorite picture or gashed your face with the ash tray, you might very well say that you were through with me ; that I could tell you my anger but you weren't going to have me around destroying things. That's what I'm afraid I will do.'

A. 'And if I said that ? '

P. 'Well, I'd lose you and I need you. You're all I've got ! '

A. 'All right. What if I did turn you out ? '

P. 'I'd be furious and I'd say to myself that you weren't any good anyway.'

A. 'But you've just said that I was important to you, that I was all you had.'

P. 'Yes, but I'd be too proud to acknowledge it and anyway I can get along the way I am, even though I am mad all the time, even though that makes me unhappy and despairing. I'm used to it and know how to deal with it.'

A. 'If I'm so valuable to you, why should you let me go so easily ? '

P. 'But I've already lost you.'

A. 'Only if you really killed me, would I be lost. If I'm in the world and you're in the world, there's always the chance of getting me back again.'

P. 'I don't see how. I could try to come back here again. But, of course, I'd have to admit that I was glad I'd finally lost my temper at you, that I'd finally told you my real feelings, and that it was the best feeling I'd ever had.'

A. 'Of course.'

P. 'But then you'd hurt my feelings again.

You might say that even if I had been honest, you couldn't have me around.'

A. 'I'd throw you out again ? '

P. 'Yes, and I'd be furious ; and I'd never come back.'

A. 'I'd still be lost to you. But, you know, I'd still be here.'

P. 'I don't see any way of getting you back. I might kill myself.'

A. 'Then you would surely lose me.'

P. 'Or get very sick. No, I can't see any way. I'd be too proud to let myself know that I had to have you.'

A. 'But you're an ingenious person. You can imagine some way of getting me back, even if you've never experienced it.'

P. 'I might get sick with brain fever.'

A. 'Why that ? '

P. 'Because I love you so. *There,* that's it. How did that feeling ever come out ? It came out without my knowing it. But how could I ever show you that I love you if I also get furious with you ? I'd want you to love me. I might discover a cure for cancer.'

A. 'Why should that make me love you ? '

P. 'I'd be admirable.'

A. 'But that doesn't mean you'd be lovable.'

P. 'I could pretend to be lovable.'

A. 'But I'd probably see through that and not like it.'

P. 'I don't know how to be really lovable. And yet I can be such good friends with the stenographer or the elevator boy ; lose my temper at them and still be good friends.'

A. 'Perhaps that's because it doesn't really matter if you lose them. It does matter if you lose me.'

P. 'What the Hell ? Then I wouldn't have this damned mess on my hands ! '

The hour ended here, and without relief in the patient's tension.

In the dreams is seen a slow acceptance of his knowledge that he must now face me in whatever guise I might seem to him to be at the moment. All the feelings of fury, impatience, jealousy and envy, which had been so disastrous in his relations with others, had lately seemed to direct themselves at me. He was in constant fear of physically destroying me and so proving to others the reality of the insanity which he imagined they suspected in him. He was also afraid of being himself physically and mentally destroyed by his overwhelming force of feeling. These fears were in conflict with his belief in my sincere wish to help him to get well. There then arose in him the stubborn refusal to give in to me, the refusal to admit the success of my analytic treatment by getting well. It would be better not to improve in health and so to beat me at my own game. He could manage, now that he was somewhat better. He could get along, and his present state was a familiar one. To make the plunge, to fly over the desert, even if it might possibly bring him real recovery and happiness, might on the other hand end in complete disaster. Better to stay as he was than risk failure, especially as in staying as he was he remained in power over me. This battle was accompanied by feelings of great despair. His life outside the analysis was sterile, meaningless and automatic. He tried not to think of me or of his analysis and took refuge in his old defences, realizing at the same time that they held no protection for him. This was extremely wearing to both him and me. But he soon learned that my admission of defeat was of no help to him, was in reality a hindrance, as it lessened the tension of his struggle. He alone must fight the battle and win it. With this realization, these questions arose at last in his phantasy : Does hatred preclude love ? Might not winning the fight be a way of winning my affection, even if it necessarily involved the expression in words of his direct and passionate aggressiveness towards me ?

V. *Fifth Stage of Treatment : The patient safely re-lives the traumatic experiences of his early childhood through direct, crucial and aggressive emotional conflict with the analyst.*

In the previously quoted hour we see the patient contemplating what he has always feared might happen to him. He feared that he might violently and destructively express his feelings, most particularly his hatred, in such a way that he would lose all that meant security to him. Gradually during his analysis he has learned to realize his fears of this possibility and, gathering his strength, has determined to discover whether, if he dares to feel the aggressiveness which has become increasingly directed at his analyst, he will actually suffer the destruction that has always hauntingly threatened his life. This attempt he can dare to make because, through his constant testing of the analyst, he has gained considerable trust in him. He now knows that, if he should allow himself to feel the fury of anger or of love that seems to possess him, he may gain immeasurably and may find a new health. If he fails, life can be no worse than it has always been. There is really no choice of action, for his former neurotic weapons have become valueless. Nevertheless, many months of hesitation pass. The pros and cons, dramatized emotionally and in behaviour, seem to be revolving in the patient's unconscious, as he metaphorically girds up his loins to do battle, anticipating his own active rôle as antagonist. The analyst watches the preparation of the battlefield, and aids by refusing to let the patient's attention wander elsewhere. As we have seen, dreams are invaluable in estimating the progress of these preparations, and the directions which they are taking. They are also most important prognostic signs. At the approach of the final crisis of the analysis, they

tend to recapitulate symbolically the actual traumatic occurrences of early childhood. This recapitulation may possibly form the stimulus which tips the balance in favour of succumbing in the analysis to the re-living of the trauma.

Example: The following series of dreams and associations occurred in the third and final year of analysis of a patient suffering from deep depressions. In them we see an outline of the constantly shocking early relationship between the mother and this child, and the child's reaction to this relationship. Increasingly evident is her eventual unconscious determination in the analysis to break through the vicious circle of her neurotic protections against the traumatic experiences and, by direct aggressive expression against the analyst, to fight for her independence and integrity and to regain the happy temperament which she grew to believe was hers by nature.

Dreams: (1) 'I went into a room where there was a little girl. She was my little girl. On the plaster wall there was a fuse-box and all around it some child had stuck her fingers in the soft plaster, so that there were holes. It looked terribly messy. I knew that it was this little child who had done it and I scolded her and told her that she must never do it again. Then I had to go out of the room for a while.

'I came back and all around the fuse-box in designs were nails, copper and brass nails, very shiny. The little girl was sitting on the floor looking up at this, and over by the window was an older girl. I was furious that the little girl had done this to the wall after I had told her not to. I picked her up and beat her till she was just a little mass of white clothes, and threw her into the corner of the room where she lay like a heap of old rags.'

Associations: 'Mother always said that she never spanked me. The other children had been spanked but I never had been. The little child was myself. B., my sister, was sitting by the window, watching mother spank me. B. knew that she herself had made the holes for mischief. The little child was too young to drive all those nails in, in designs, herself. B. had betrayed me although I had always worshipped and adored her. Perhaps I had called to mother for help if B. had teased me. Mother came in and, instead of helping me, fell upon me in a fury, because she thought that I had done what she had already told me not to do. I can feel myself to be that pile of white clothes—crushed and almost destroyed—and the two people whom I had counted on, loved and adored, had betrayed me. Since then there has always been a conspiracy to keep up the fiction that I had never been spanked, because the one time that I was spanked, mother almost killed me and didn't want to remember that. I didn't want to remember it either, because it stood for the moment when I lost everything. And B. didn't want to remember it, because she was guilty of letting me be punished for her, letting me be almost killed. So we have all been living the lie that I was never spanked.'

In this dream and associations, we have perhaps a recounting of an actual very early trauma, before the patient could talk. She remembered that in her later childhood her mother had often comforted her when she had been hurt, had taken her on her lap and dried her tears; but this time, she had fallen upon her, 'like an avalanche', and had beaten her until she was limp. Then, leaving her in the corner of the room, she had deserted her. For some time after this occurrence the patient never left her mother's skirts and in so doing assisted in establishing another fiction, that of being a model child who never did anything wrong. A most important element in this dream is the identification of the patient with her mother, 'identification with the enemy', and the clear picture that is given of the moment in her life when, through this identification, she attempted to destroy a part of her own personality. 'I beat her until she was just a little mass of white clothes.'

(2) 'A set of short dreams, all very vague and as if I were a ghost in a haze, returning to visit the rooms and people whom I had loved and where I had lived:

(a) 'In a bed with lots of starched, long, lacy petticoats. I felt smothered by them and a little curious of what was underneath them.'

Associations: 'The long period of sitting at mother's skirts. I was dead then, hypnotized, drugged. The instinctive wishes were there but hazy as in a dream, foggy.'

(b) 'I was going to a dancing party and wanted a gardenia to wear. I went to a green-house to buy one but the man said that the gardenias were too far away for him to go and get one. Instead he offered me a china vase with pale blue, stiff little flowers growing in it, very artificial and not what I wanted at all. I took it.'

(c) 'In Maine, very beautiful weather, lovely scenery, spring. Good to be alive! You were with me. I told you of some lovely sugar maples that we could tap, for the sap was now running, and it would be such fun to make sugar. We started out so happy and gay, when someone called me from the house. A lot of business-like, efficient girls were in the kitchen packing up to leave. One of them told me that I must fix the stove and put some cellophane over a hole on the side of the stove. I didn't want to do it or to cook, or to stay in the house; but I knew that I had to.'

This second set of dreams continues to depict 'the dutiful child' sitting always at her mother's skirts. The memories of this part of her life had been brought to the analysis during the first year and we knew thoroughly all the details. The child had sat by her mother for hours on end, afraid to move, afraid of her teasing sister; and, fearful

that she might be scolded by her mother, she had watched her mother's every move, learning how to identify herself with her. Again a fiction sprang up in the family. There are letters written by the mother telling of little Mary's angelic disposition, how changed she was, how quiet and good, and how devoted. 'She doesn't leave my side for a minute and sits by my skirts for hours doing nothing at all.' These dreams, beginning with quantities of stiff, starched petticoats and a china vase of stiff, artificial flowers, give symbolically and very accurately the thoughts that must have run through the child's mind as she sat so quietly by her mother's skirts. The little girl did not dare to breathe her wonderings. All she dared be was a ghost, visiting the places where she had been happy, looking at those whom she had loved and lost, not daring to be alive, nor to remember what had occurred before she had been so cruelly beaten. 'Hazy', 'foggy', 'like a ghost' are her associations to these dreams and we see that, although she knew what she wished to do, the slightest hindrance or wish from another person controlled her actions.

Here we have the continuance of the original repression. It is well installed, and the failing child has become a little ghost allowed to wander at will through all the childhood haunts but warned by some dim dreamlike memory never to dare to come alive again. This spectral existence at her mother's feet, protected from all harm and conscious fear, has the aspect of a hypnotic trance. This living death, like all repression, existed parasitically on the strength of the phantasy 'as if . . .'. 'I am acting as if I were alive, as if I had never lived before. My other life was a lie. It didn't happen.' The last dream of the series, however, is full of hope that somehow she may feel happiness again. It forewarned me of her coming attempt to bridge the gap between her present analytic situation and her earliest and happy infancy. She wished me to accompany her on the adventure. But before we could 'go out into the woods to tap the sugar maples' she herself must accomplish a difficult and trying piece of work.

The final dream occurred several weeks later when the patient was ill with influenza.

(3) 'I dreamed of a whole pile of old clothes made of small bundles of old clothes. The whole bundle was I. It looked the way a bundle does when you hold your arms out and hang clothes on them, entirely limp, hanging there, even more relaxed than a baby who is asleep. It seemed like a baby that had lost consciousness completely.'

Associations: 'I know now exactly how I felt before the first terrible punishment happened. I can remember the feeling and I've never felt it since. I can see that I've always been trying to get it back. Mother wrote in her letters that I always "danced along" when I first began to walk, that I never just walked. I was so full of life and energy and joy, of a strong passionate feeling of loving. Such feeling is always aggressive. It is sheer passionate feeling with no differentiation of love and hate. In that dancing, happy mood of strong feeling, I may have lost my balance and fallen down. It would not have been my fault at all, someone might have tripped me — B., in teasing me. Or I stumbled because I was just learning to walk. I hurt myself, skinned and bruised my knees. Then, instead of being picked up and loved and encouraged back to self-confidence and high spirits, mother shook me and scolded me and was angry because I hurt myself and tore my dress. I have often seen mothers and nurses treat children that way. I was so outraged at being scolded and even more hurt, when I was already in pain from my bruises, that I tried to pull away from her hands and arms, tried so hard that I kicked and screamed. She held me tight and I began to feel a frenzy of hatred. Before that, even after I had fallen down, I had been happy, in loving her so passionately and wholeheartedly. Suddenly, with her anger and her restraint of me, hate came into my heart. Then she must have caught me and beaten me and beaten me, until in self-defence I lost all sense of where I was. When I came to, I was in the same house, with the same people, but everything in me was entirely different. I had died as the passionate, strongly feeling, dancing child. I was a ghost and from then on, I felt like slimy, grey, nasty sputum.'

In dream (3) and its associations, no new material is found. We are, however, led back by the symbol of 'old clothes' to the first dream of all, and find that during the three groups of dreams covering a period of six weeks in the third year of analysis, not only have memories of an infantile trauma been reconstructed, but the memory has been recovered of a sense of well being, of joy, and of a passionate happiness in loving that can be with difficulty reconciled with the patient's life as she had hitherto described it. This last memory, when once re-awakened by the emotional stimulation of dream (3) and its associations, became so ingrained in the patient's consciousness, that her one ardent desire was to re-experience this condition. This, she felt sure, was her true nature, her birthright. From it she had been driven by a succession of shocks and losses that had necessitated the primal repression, its maintenance, and its fortification by means of later repressions.

During several weeks after these dreams, I could sense the gradual approach of an attempt to recover, as an actual experience with me, the complete memory of the traumatic event and of what her life had previously been. She seemed to realize that only by unreeling the film backwards could she get to the other side of the trauma, to her real nature, to the happy dancing little girl. It was as if, all unaware, she were preparing herself and at the same time relaxing her neurotic defences.

The angry, ardent side of her personality was growing in proportion to her ability to entrust herself to my care. At this stage of the analysis, she reminded me of a butterfly within the chrysalis. As the chrysalis becomes more and more weakened and brittle, the butterfly within slowly comes to life, grows in vitality, and fearfully pushes its way out into the light. Perhaps the insect at such a moment feels the sense of shock and apprehension that overcame my patient during two particular analytic hours when she finally emerged from the crisis and realized the uncontrollable impulse that had but a moment before held her in its sway.

As a result of the slight glimpse aroused by the third dream into her earliest and apparently joyful infancy, she grew more aware of the frustrations and deprivations that now separated her from the happy state of mind that had been recalled. Her behaviour to me became increasingly that of a passionate imprisoned child. Her reality situation, as well as that of the analysis, contrived to repeat almost in duplicate that of her childhood. Whatever she desired seemed to be just beyond her reach. She became very restless and very eager to escape from her immediate and excessively frustrating environment. An opportunity offered itself in an invitation to visit one of her children. She rather fearfully asked me if she might stay longer than a week-end, in case she found she was capable of enjoying herself. I encouraged her to do this. She stayed five days, surprised to find herself happy and carefree.

Upon her return to the analysis, however, the hopelessness which had increased to an almost overwhelming extent through the past few months, again enshrouded her. I could see in her daily reactions to me, in her fears and impulsive wishes, and in her timid attempts to break through the restraints that I represented, the duplication of the days at her mother's skirts. This frame of mind became increasingly intense after her trip. As I constantly confronted her with her slavery to me, she became more and more infuriated with me, her slave driver; but she, nevertheless, begged me to let her come to me at any time that she felt her uncontrollable reactions threatening her. This I promised. My co-operation with her deeply repressed impulses helped to allay her intense fears. The child that had sat at her mother's feet had unconsciously learned to keep in check her impatient and angry feelings by means of an unattached anxiety, which had arisen from the forgotten suffering at her mother's hands. For her to allow these angry impulses expression she needed a safe and tender mother. Only by very gradual and frightening tests could she believe that I might be such a person. In many analytic periods she proved my sincerity, my patience and my self control. At the same time she became increasingly importunate, angry at the deprivations of her reality situation and overwhelmed by an unbearable longing for a safe and tender relationship with me. Finally, after an exceedingly stormy analytic hour, she telephoned and asked to come to me again, saying that she could control herself no longer. At the end of a period of two hours of intense agony, of complaints and anger and despair, long periods of hysterical sobbing and cries of woe, she cried herself quietly to sleep in my arms. In the interval before her next analytic hour she realized that she had, during those two hours, been possessed by an emotional state which had lacked all conscious control, that for moments at a time she had not known what she was saying or doing. To awaken and find herself safe, and to find that I had kept my word that I would protect her, gave her the courage in herself and faith in me to continue in her willingness to expose herself to such experiences.

This occurrence brought on a period of several weeks of nursing memories and reconstructions of her infancy. She happened at this very time to learn from an external source that three weeks after her birth her mother had, for a few months, sent her each day to a friend who also had a new-born baby, to be given supplementary nursings. In my patient's mind this necessity seemed to be due to some fault of her own. Stimulated by this distasteful information, the actual deprivations of her present situation assumed an aspect beyond endurance to her. She became more and more flooded with anger. She was filled with furious passions throughout her waking hours, occasionally venting her rage in destructive tantrums in her own home. I realized the danger of a physical attack on me and questioned whether this could be prevented without losing the therapeutic value of such a re-living. I believed, however, that her greatly improved mental health, her increasing self-confidence and her admitted need of me would tip the scales in favour of a successful outcome of her present conflict.

Here the question of the diagnosis of the patient's illness is of extreme importance, as it is to a less degree throughout the treatment. If the patient is a border-line case and if there is, therefore, a chance of his seeking refuge in a psychosis, it is necessary, through the entire therapeutic process, to watch assiduously and sensitively the level of emotional tension, to relieve it when necessity demands, and not to allow the patient to run any risk whatever of succumbing to such a complete emotional seizure as was allowed in the case of the psycho-neurotic patient here described. In a border-line patient one cannot depend on the normal self-protective element of fear which, like pain in organic illness, acts as a warning to the individual to pursue no further his present course of action. This protective mechanism of normal fear must be distinguished from neurotic anxiety. It is not without real cause and can be counted

upon to interrupt at the vital moment and to prevent the consummation of an irrevocable destructive act. There is experience in such a seizure as I am here describing, the almost complete yielding to an overwhelming impulse and also the sure rescue by fear before actual harm has been done. This rescuing element functions more and more effectively as the neurotic patient grows in mental health and in the consciousness of his integrity and emotional strength. Such a condition had in this case been achieved and the moment had arrived for me to allow her the freedom to act, which she was unconsciously struggling to obtain.

Finally, in one of her analytic hours, I found myself obliged to refuse an invitation to lunch with her. Suddenly she threw herself at me, screaming out her angry wish to kill me. I put my arms around her and we knelt together by the couch, she sobbingly asking me if she had hurt me, telling me that I should never have let her reach that point of lost control and that it was my fault, and not hers. Gradually she began to realize that she had experienced the power of an instinctive impulse in its direct expression and had repeated in this temper tantrum the kind of emotional seizure which she had felt as a child and which she had described in her associations to the third dream.

For the next few weeks she expressed in words and mood the probable reactions of her mother to her original tantrum, and of herself towards her mother. First she would denounce her own furious impulses, feel ashamed of them and try to prove that they brought her scorn and ill-treatment from others. In actuality she imagined herself openly shunned by her nearest friends. Then she would denounce me for being the occasion of the tantrum, saying that I, and not she, was responsible for it. Slowly these reactions against her angry impulses and their expression weakened. She realized that her passionate and almost unconscious rage had had no ill effects ; nor had it changed the frustrating facts of her circumstances. Again came periods of complaint and anger, but the anger came in more verbal expression than she had ever allowed herself to use, and was not repeated in a direct motor discharge. In time, these reactions were replaced by wonder that she remained unpunished by me and that she had actually harmed no one and was herself unharmed. She was astonished at having feelings of remorse and love towards me and on one occasion was impelled to telephone to me for forgiveness. She did not follow this impulse, however, as she also felt angry with me. The next morning she greeted me with expressions of surprise. She had had an entirely new emotional experience. Throughout the previous afternoon she had been a prey to conflicting feelings : intense impatience with me ; anger and fear of anger, mingled with feelings of love for me ; and despair at not being able to possess me. She had later gone to a very beautiful concert with an intimate friend of her mother and had been astonished to find that, although she felt constantly the instinctual battle of love and anger raging in her, she was also able to feel a certain happiness and quiet peace, and a delight in the external circumstances of the evening.

Her next lesson, and the final one of her analysis, she soon learned with great surprise. She found that it is possible and desirable to allow oneself to recognize and to endure these battles of love, longing, need, frustration, anger and fear, which are a constant accompaniment of life ; to keep them, by acknowledging them and not denying them, on a deep but conscious level, thereby freeing the upper levels of consciousness for the minute-by-minute perceptions and reactions of everyday life. After several months of such revaluation, fear of her instinctual conflicts was removed and her constant sense of irremediable damage to herself vanished. The memory of this damage became valued as the evidence of her rich and passionate nature, and as the symbol of her capacity to bear suffering. Thus the more normal expression of her masochistic instinct superseded her life-long indulgence in the states of depression and self-despising that had previously threatened her existence. She was now able to undertake her life in reality, with a self-esteem based primarily on a new confidence in her instinctive nature and in her endurance.

Ferenczi's belief was that in this active and somewhat violent stage of the analysis, the analyst himself can be less active than heretofore. In the earlier stages he has been obliged constantly to prod the patient out of his defences and to entice him into greater emotional activity, in order to bring him at the earliest possible moment face to face with the anxiously dreaded situations which have haunted him since their first appearance in his infancy. As his emotional strength increases with exercise and understanding, he at last dares to take this last step, dares to unleash the feelings that have never before been allowed full expression. This he can only do if he is confident that his analyst will protect him against destruction, that of the analyst, of his surroundings and, in consequence, of the patient himself. For a period of time these impulses are 'nip and tuck' within him. The analyst awaits the outcome. At this moment there needs to be no prodding, no interfering on his part ; only an occasional honest expression of his own feelings, when there is danger of a slackening tension. He has initiated the momentum and it will run its course if undisturbed. At this time he need only stand prepared to assist his patient to gain greater strength in self-confidence after he has dared to make the plunge into the sea of his emotions. He waits, as does the mother with her arms outspread to catch the little

son as he takes his first running steps. The patient's entire concentration is focussed on this critical feat. Its successful outcome opens up a new world to explore.

VI. *Sixth Stage of Treatment: The patient, relieved at the unexpected outcome of his conflict with the analyst, casts away his distorted sense of values and, learning to measure his growing reality-sense by means of the realities of the analytic situation, finds the analytic relationship no longer sufficiently satisfying or necessary to his life adjustment.*

The discovery that his neurotic fears were based upon an entirely false premise comes as an overwhelming experience to the patient. That he does not himself disintegrate from the strength of his passions, nor destroy the person who is to him most precious and therefore most frustrating, nor lose his affectionate respect, is astounding to him. He has felt the extreme force of his feelings and cannot belittle it in his own mind. He has also experienced his intense struggle to control it, at first by his neurotic protections against it and finally in his healthier power by expressing it vocally, or even to some extent physically, without bringing about any actual destruction to himself or to anyone else. This more normal control is based on the recognition that he most loves the person at whom his hatred has been directed; that his feelings of resentment and anger are in themselves worthy of respect, and not in any way shameful; and that his deep affection and need for the object of his anger are even stronger and more permanent than his attacks of rage.

The outcome of this final crisis leaves the patient emotionally exhausted, and he turns to the figure of his analyst, again wondering how the latter can have borne with him. He recalls each step of the battle, revaluing it, not through the delusions of his exaggeratedly aggressive feelings but on the realistic basis of justified irritation and of affection. He sees the analyst's tolerance, his patient endurance, and feels blessed in the security that he has found in him. From day to day he more clearly recognizes the many rôles that the analyst has been forced by him to play in his phantasy life. He admits into greater consciousness his need to gain his analyst's love and admiring respect. At last, in winning the battle by his own great efforts, he achieves a belief in his endurance and strength. He has attained his integrity. This he recognizes as something of consequence to offer as a reward to his analyst and friend.

These realizations form the kernel of a developing sense of reality which automatically takes the place of the destroyed kernel of his neurosis. The patient now views his personal relationships in their actual light. He knows his own needs and begins to consider not only what their limitations are, but also how they can in reality be satisfied. This again leads him back to his analyst. He longs to keep his new-found security in him, to possess him for himself. But here his budding reality sense and his analyst's own admissions make him aware, slowly and very painfully, that the analyst cannot reciprocate his own feelings. He is already a secure person, with many other interests and concerns. It is true that he has proved without a doubt that he is a devoted and loyal friend, a good and dear parent. The patient is, however, being forced to realize that the analyst has no great emotional need for him. The analyst's wish, as far as he is concerned, is for him to be well and to take over his mature responsibilities. In relinquishing his illness, he must accept separation from his analyst.

Needless to say, this is a difficult stage in the analysis. Here the analyst's tact, subtlety and honesty are of the greatest moment. To help his patient to evaluate him as he really is, without dissipating his new-found feeling of security in him, evokes a very meticulous and sympathetic skill. It is probable that the analyst's sincere evaluation of his own personality and a willingness to learn from his patient of his own short-comings, changing them when possible, are among the most essential elements in the development of the patient's growing reality sense, his tolerance, and his capacity to bear disappointment. Little by little the analyst stands out more and more clearly defined, with his many dissatisfying qualities and his frustrating limitations. This new capacity for critical appraisal deals first with the analyst and spreads later to the whole life of the patient, until he becomes so absorbed in the excitement of realistic living that the analysis no longer holds sufficient interest or value for him.

Example: Exchange of the ghostly illusions of the neurotic past for the actual conditions of the present can be observed in the following example of a patient in the last month of her analysis. She had spent the immediately previous weeks in recognizing her loving devotion to the analyst, her dependence on her, and her wish for an indefinite continuance of the fond maternal care which she had now found for the first time in her life. She had found in me a mother whom she could love, and of whose interest and affection she was sure. Why could she not keep me forever, live with me, rely on me for help in all her problems, spend her days with me as a favourite and beloved daughter? She used many analytic hours in demanding this love, begging for it, insisting upon it. She had finally the courage to ask the reason for my not giving it to her. I explained that I hadn't it to give—that I led a very full life as it was, and that there was necessarily but little room in my life for her. To have this actually said to her was very terrible, as it left her with no hope of obtaining what she so passionately desired and had had the bravery to plead for. Days of grief and frustrated anger alternated.

At this time she planned a week-end in the country near my summer home, and asked me as she was leaving if she could do any errand for me while there. I said that if she really wanted to take the trouble, I should like to have some asparagus picked and brought to me. Her ambivalent reactions were at once apparent. She felt that she was being treated as a servant. This was the kind of demand that her mother would have made on her in return for her affection. The following day she drove over to our farm and looked at the asparagus, deciding to return early the next morning to cut it. It was a very beautiful afternoon and she lay on the grass by the house watching the sunset, smoking a cigarette and enjoying the illusion of possessing me. She was there alone with my house, it could not resist her or refuse itself to her. She was in power. She finished her cigarette and, remembering that I had once told her to throw the lighted end on to the grass where it would safely burn out, she started to do so. A sudden picture of my house in flames flashed across her imagination. She would do what I advised and in so doing she would destroy me. Terror seized her heart and remained there, although she very carefully and deliberately extinguished the cigarette end. Each moment of her returning drive she saw herself throwing the lighted end on to the grass and saw the house in flames. All the evening she continued shudderingly to see it. She spent a sleepless, frightened night, impelled several times to dress and start for my farm. Finally at daybreak she drove over, to find the house safe, calm and reassuring in the light of the early dawn.

Again she lay on the grass and smoked a cigarette, pondering over the past twelve hours. As a child she would have obeyed her mother to the letter and have thrown the lighted end on to the grass. If the house had burned down and her mother been killed, it would have been her mother's fault. The terrible compulsion to destroy her mother by meticulously obeying her and to punish me for my unavoidable withdrawal from her, had been dramatized in the frighteningly realistic phantasy of the afternoon and night. In spite of the compulsion she had not obeyed her mother, not done what I had advised; but had used her own judgement, saving the house and me from destruction, and this despite her sorrowful knowledge that she must soon be denied my maternal care. Here, too, was dramatized her decision at least to keep me in her heart, to cherish me by her own developing maturity. A great sadness and loneliness came over her as she accepted these difficult realities in place of the earlier neurotic illusions. As a little girl she would have forced herself to prove her love for her mother in ways that would have brought angry punishments upon her and have aroused in herself equally angry and destructive wishes. No longer, however, did the passion of anger satisfy her; nor was her passionate love for me of any avail. Only grief seemed left for her.

This week-end experience gave her great confidence in her own intuitive judgement, in her unexpected ability to stand the depths of anxiety and the pain of separation and loss. She no longer feared that she would, in the despair of frustration, destroy what was most precious to her, but found that she could instead preserve her love and maintain her own integrity.

Here we see in a dramatically phantasied form the actual content of the last period of the analytic treatment. Sorrow and the increasing ability to bear sorrow, together with the determination and capacity to find happiness, are the essential characteristics of this final stage. To have won the power to love, to be forced so soon to recognize the tenuousness of the object of one's love, is indeed a grief. To admit one's grief, keeping indestructibly in one's heart the feelings of love, and, in spite of the sorrow of loss, to achieve happiness, is a difficult lesson to learn.

A sense of magic pervades the last step of the analytic process. The dream of victory, of the acquisition of self-sufficiency and integrity, of out-going love and generous gratitude, of deep need and deprivation, and of grief, is shared with the analyst. As the demands and pleasures of the outside world call more temptingly, and the new strength longs to be exercised, the mature and healthy individual is eager to answer and sees in these calls an opportunity to prove his devotion to his loyal friend and to himself. Every mother knows the experience which the analyst must at this moment undergo. He rejoices and is sorrowful with his patient, but his own happiness lies along the very path which the patient is now intent on following. The final day of the analysis may come unexpectedly and 'Farewell!' is said by two friends of long standing. Analyst and patient now face ahead into the future, relieved that the therapeutic struggle is over and that a well-equipped and maturing human being is re-entering life.

Summary.

In describing the somewhat arbitrary divisions of the analytic process, and in quoting dialogues, series of dreams and phantasies, behaviour during the hour and outside the analysis, from cases illustrative of such periods, I have tried to show a few of the many ways in which a vital relationship between analyst and analysand is essential to the success of the analytic therapy. It is this vital relationship which Ferenczi considered the nucleus around which the analyst's technique should revolve. As the cases reported had necessarily to be taken from my own practice, the descriptions and conclusions are, of course, the outcome of my reactions to the individual patients and of my

attitude towards the experience of being an analyst. I can only hope that I have succeeded in giving some indication of the broadly human scope of Ferenczi's technique.

Objections to Ferenczi's Technique

I have attempted to summarize the outstanding contributions in the therapeutic technique of Sándor Ferenczi to that of the strictly Freudian school. These have aroused in the psycho-analytical world sincere and serious questioning as to possible inherent difficulties. Four such objections stand out most prominently: to the use of the counter-transference as a technical instrument; to the analyst's attitude towards the patient's resistance; to the necessity of re-living early traumatic experience; and to the dramatic tone of the process.

(1) To use the counter-transference as a technical tool, as one uses the transference, dreams, association of ideas, and the behaviour of the patient, seems to many analysts exceedingly dangerous. Much of this anxiety has to do with the analyst's fear of his own impulses, his intuitional weakness, and his lack of self-knowledge. In so far as this is true, it points to the need for further and deeper analysis for the analyst, so that he may strictly and thoroughly know himself and his limitations. But, in addition to this, there is often among analysts a preference for the teacher-pupil relation, a didactic and distant attitude towards the patient, rather than the tender parental attitude. The teacher relation allows the analyst to keep himself apart from his patient, to divulge just enough of his own personality to control the patient's confidence in him, to remain strong and self-assured in the eyes of himself and of his patient, and to give help to the patient as a beneficent gift. The basis of this kind of treatment seems to be anxiety, as evidenced in the analyst's insecurity in himself and in the patient's awe of the analyst. The patient learns because he must, and the hypnotic tie that binds him to the analyst may in the end be far more unbreakable than the tie of tender devotion.

The benefit of the direct and fearless technical use of the counter-transference lies, as I have said before, in the development of a real situation and its use. The analyst, a human being himself, cannot but have emotional reactions to the patient and to their mutual situation. The truth is that in the analytical consulting-room there are two people, each living vital lives, each bent on solving one and the same problem, meeting day after day for several years, growing to know each other better with every day. It is impossible to imagine and ludicrous to assert that an emotional relationship on both sides must not inevitably develop in such a setting. It is outside the realm of possibility that an analyst, who is sincerely determined to cure his patient, does not grow to care for him.

The difference in quality between the analyst's feelings for the patient and the patient's for the analyst lies in the safeguarding fact that the analyst understands his own emotional reactions. This understanding allows him to make right use of his trained and intuitional skill and prevents him from allowing his own personal problems to enter upon the analytic scene. As a patient recently said: 'I must trust you not to bring your problems here to me. You should be well enough to settle your own affairs, at least not to burden me with them!' This patient was warning me to watch carefully lest my emotional reactions be unconsciously vented upon him. There is only one source of prevention for this and that is the analyst's thorough understanding and control of himself. This, however, is one of the prime requisites in all analysts. If a technique must guard against the analyst's lack of self-knowledge and self-control, the foremost therapeutic value is lost. The analyst should be constantly aware of his own personality traits and should constantly take into consideration the fact that they are impinging upon the patient's personality. They should be mutually dealt with, not as the analyst's personal problems, but as facts—which indeed they are. In this way the patient is being exposed over and over again to actualities of his reality situation and derives permanent benefit from the exposure. To seize the most appropriate moment for this experience is an important attribute of the analyst's skill. The content of his reactions does not compare in significance with the time, and with the honest and tactful manner, of their expression. The sure criterion of such technical 'activity' is the question: How can I best assist my patient at this particular moment? The analyst should know when the acknowledgement of his own feelings of affection, of confidence, of admiration, of impatience, of weakness, of discouragement, of temporary dislike, of actual incapacity, etc., can be of benefit. At the beginning of the treatment such an admission often serves to clarify in the patient's mind his own protective mechanisms and focuses his attention on his own habits of thought and behaviour. At the critical moments of the analysis the analyst's reactions often raise the tension to the important breaking-point and at the same time give the patient courage to face this greatly feared test. During the last period of the analysis such acknowledgements by the analyst help greatly to develop the patient's sense of reality and in the end prove to him that neither the analysis nor the analyst can offer him exclusive satisfaction now that he is well.

In the more usual and didactic form of treatment, the patient is constantly dealing with an unknown quantity as far as the counter-transference is concerned and is at the mercy of the analyst's authority and artificial strength of position. Although such treatment may cure the

neurosis, Ferenczi thought it could not lead to a sufficiently thorough and permanent establishment of the patient's personality.

(2) The mechanism of resistance is in the minds of most analysts a stumbling-block in the path of the cure. It is to be feared and to be dissipated as quickly as possible. This point of view seems to be largely responsible for the generally practised 'passive' technique. As long as the analyst remains as the quiet screen upon which to project the moving picture of the patient's past and present life, the patient's resistances need only be dealt with impersonally and objectively, and therefore with greater ease and less fearsomely, usually by means of interpretation. If the analyst, on the other hand, takes an active part in the analytic process, he comes vividly to life and the resistances become more powerful and stubborn, and tend to be directed at him. Confidence in him, however, is simultaneously increased by his very aliveness and allows the patient to bring the highly charged situation into the open. He feels himself in actual conflict with his analyst, duplicating the difficult or traumatic occurrences of his childhood. That his analyst reacts in his own individual manner and differently from the personalities in the patient's earlier life is a fact that gradually dawns upon his consciousness and finally sweeps away the resistances.

Ferenczi welcomed resistance as an essential part of the patient's emotional make-up. It is in resistance that emotional tension is at its height and that the expression of sheer feeling is given vent to in its most unadulterated form. The result of allowing the tension to increase gradually throughout the analysis, until it becomes unbearable and breaks down the protective barriers, contributes not only to the patient's eventual relief but to the analyst's immediate, and to the patient's ultimate, understanding of the manner in which these highly important parts of his personality have always functioned. It is only in maintaining resistance and increasing it to the breaking-point that the patient tends to lose temporarily his sense of reality and can actually become the infuriated, or the impenetrably stubborn, or the desperately forlorn child that he once was. To alleviate the tension by interpreting the resistance, as many analysts do at the end of the analytical hour, deprives the patient of his courageous and needful attempt to re-live the moment of his life which he most greatly dreads, and, in so doing, deprives him of his growing potency. This is an easier and less frightening course for the analyst than to maintain the resistances. To watch and encourage the growth of emotional tension is a difficult and anxious task. In this way, however, a lesson is learned by the patient through actual experience which no amount of teaching and explanation can ever accomplish. Such an experience of re-living is for the patient an incontrovertible proof. Both patient and analyst have been preparing for this moment for many months. It does not come suddenly or unexpectedly. But until it is undergone and has become an actual part of the patient's life this lesson cannot have a sufficiently solid and eternal quality.

(3) The therapeutic necessity for the actual re-living of early traumatic experience is frequently questioned. Could not the same results be obtained, it has been asked, and the analytic process shortened, by assisting the patient to the emotional experience of gaining insight only? Does not the excitement of at last fully comprehending his method of functioning, without the deeper experience of re-living, make a sufficiently intense and immediate impression upon the patient for him to be able thereafter to call this lesson to his aid at critical junctures and thereby cancel any need to repeat his former neurotic way of life?

Such a situation arose in the case of a young man who, during the first year of analysis, became increasingly convinced that his mother's sudden death, when he was five years old, was responsible for his neurosis. During a certain analytic hour, under great emotional stress, he again reconstructed the death scene. In his loneliness and longing for her during her illness, he had pushed open the door of her bedroom and had immediately been reproved by her in a sad and very tired voice. At this unexpected rebuff the world had fallen from under his feet and when he was told the next morning of her death, it was no surprise. From that time on he, too, had not dared to act as a person alive. This recovered memory had ended the analytic hour and I had joined my family at tea in the living room. Suddenly the door was pushed open and the haggard face of my patient reappeared. 'I must talk to you again!' he said. I returned to my study with him, to be told that at last he understood the crux of the whole death scene. As he was leaving my house he had suddenly realized that when, as a little boy, he had opened the door of his mother's room, he had not known that she was ill, he had not understood her absence from him, and he had in desperation played a kind of mischievous joke on her, pushing the door open and calling 'Boo!' at her. She had formerly always responded to this loving play, even when most cross or impatient. In delight and loving anticipation, and sure of success, he had thrust open her door, only to be reproved and rejected by her dying voice. My patient was now overwhelmed by this sudden insight. He was certain that he himself was responsible for his mother's death and that on this childhood experience was based his entire neurotic character of deadness, anxiety, inability to love, refusal to find happiness. He now saw himself in the past as merely marking time, awaiting his own death. That after the analytic hour he had actually and unconsciously dramatized the death scene also made a deep impression on him. His interruption

of me, of my privacy, and his demand to see me immediately were the result of his unconscious need to discover whether I, too, would reprove and reject him. That I did not do so, but instead welcomed him and helped him to gain greater insight, initiated the cancellation of the destructive influence of this early trauma. The next morning he felt, in his own words, 'as if the spring freshets had begun', 'as if the flood gates had been opened'. In this instance we have an example of the benefit derived from sudden and exciting insight into the original cause of an entire life of depression and incapacity. He was overwhelmed, not only by this unexpected vision of the most terrible moment in his childhood but also by the extraordinary fact of his actually, and quite unconsciously, re-living that circumstance symbolically in the analysis.

It may be possible that in general such an emotional experience of gaining insight satisfies the therapeutic requirements of most analysts. Ferenczi firmly believed, however, that the patient's neurosis could not be permanently eradicated unless the patient not only recaptures the memory of the early trauma but eventually brings into the analytic framework a dramatic situation between the analyst and himself which perfectly duplicates the original experience. This duplication must be a situation which does not *imitate* the original scene, as did in this case the patient's interruption of me after the analytic hour. It must instead be the introduction into the analytic relationship of an actual set of circumstances which have to do only with the analyst and himself, but which have, however, the identical emotional tension and emotional set-up that originally existed. As I have shown in my description of the fifth stage of treatment, the unconscious, if given the opportunity and a sure confidence in the analyst, finally dares to bring such a crisis into existence. One can foresee that the young man just described will in the future also attempt, in some set of circumstances that concerns me deeply, to intrude upon me personally. This intrusion will undoubtedly be aimed at my emotional life, at a weak and vulnerable part of my personality. He will not make this attempt until he has resurrected in himself his original gay, lovable and loving nature and until he has tested my endurance in many slight and somewhat similar circumstances. The Achilles heel which he will have acutely discovered in my character should be well known to me and must not be wounded in a surprise attack. Therefore, the chances are good that in this final attempt he will not succeed in forcing me to reject him but instead will himself reject the disastrous effect which his mother's death had upon him as a child of five years. This crisis will be a safe re-living of the harmful occurrence of the past in an actual and important situation of the present. No 'emotional experience of insight' alone can so certainly prove to him the destructive influence of his early trauma or so permanently destroy his tendency to submit to such an influence.

(4) The same basis for questioning the use of the counter-transference exists in questioning the wisdom and efficacy of allowing the natural drama inherent in all personal relationships to be the dominant theme of the analytic process. We are asked: 'Is not the dramatic element a dangerous threat to the success of the technique?' 'May it not get out of hand, or seem to the patient like a playful game or artificial trick?' Attention should here be called to the fact that the patient should not sense the drama of the analysis to the extent that the analyst does, if at all. He should only be conscious of his capacity for feeling more and more strongly as the analysis proceeds. The analyst, on the other hand, with a firm grip on the reality of the situation, is merely responding to the patient's increasing emotional strength. His own feelings, in contrast to the patient's, remain in comparison quantitatively the same throughout the analysis. It is mainly for this reason that the process grows more and more dramatic in tone—for this reason, and because the patient's emotional tension is constantly approaching the critical breaking-point.

Certainly this dynamic type of analysis is more dangerous in unskilled, unwise and unsure hands than is a more intellectual and didactic type. Analysts, like their patients, tend to seek refuge in mental concepts and to function therapeutically on a mental level. They do this as a protection, for they fear to participate in an emotional drama. Undoubtedly they thereby obtain therapeutic results. But could they not approach more closely to the kernel of the illness if they used the emotional language of the unconscious, if they attempted to work on its own dramatic level? Would they not be more likely to eradicate the neurosis and then to assist in the maturing of the individual, if they dealt with him on an instinctive and feeling basis?

Again we must look at the life of the child, where every waking moment is intensely significant and is a stream of highly charged emotions. The more completely we are to undo the harm of those early years, the more closely must we approximate to their conditions. It must here be repeated that to take an appropriate and beneficial part in the analytic drama, the analyst needs a sure knowledge of himself, a capacity to use himself as a technical instrument and the possession of a carefully trained talent. Without these assets, it is certainly wiser to treat the patient from an intellectual point of view.

Ferenczi's Contributions to the Freudian Technique

Ferenczi's therapeutic technique is not in any way a departure from the basic principles of Freud's psycho-analytical discoveries. It is firmly based on

the theories of the unconscious, of repression, of identification, of infantile sexuality, of the repetition compulsion; and on those of the pleasure-unpleasure principle, and on the division of personality into id, ego and super-ego. Association of ideas, interpretation of the symbolic language of the unconscious and of dreams, the transference, the counter-transference, resistance, etc., are essential technical instruments in Ferenczi's treatment. An analysis by him was similar to a Freudian analysis, except in its vital and dramatic tone and in the importance of active participation by the analyst.

The psycho-analytic process was to Ferenczi a deeply emotional human experience, a living experience as intense and dynamic as Freud showed the life of early childhood to be, with its great conflict between instinctual and repressive forces. The treatment should not be a mere part of a patient's life, isolated and comparatively unrelated, as is the usual medical treatment by a physician or the usual educational course of lessons by a teacher. It should comprise the whole of a patient's life for the time being, as a child's life with his family forms the framework for every activity, thought and feeling, whether inside or outside the home. The simpler, more direct, more feeling and more human the process is, the more it duplicates the much needed natural warmth of the child's home experience. The more complicated, intellectual and impersonal it is, the more it represents the forces against which the child has had to contend. For the analysis to be of real and lasting avail, the patient's heart must be deeply touched. It is not sufficient to re-educate him.

In extent, Ferenczi's analytic treatment had no set limits. To help the patient gradually to gain the strength to re-experience the original trauma or traumatic series of experiences was always his hope. Or, if it was a case of long exposure to a cruel environment, as is so frequently true, to re-experience this exposure over and over again, and with increasing tension, seemed essential to a permanent cure. Such a far-reaching operation usually means a very long analytic treatment. This Ferenczi constantly endeavoured to ameliorate. How to journey as far but in less time was an ever-present problem to him. The answer to this problem, he thought, lay in the rôle of the analyst. His chief part, in addition to the application of his skill in understanding and in interpretation, should consist in raising the tension between himself and the patient in proportion to the patient's endurance. This, as we have seen, means taking an active part in a highly emotional relationship. The purpose of this is to strengthen the patient, but much more importantly to bring finally and very carefully to a head the threatening dramatic crisis.

In this crisis the seed of the neurosis is detached and brought forth. In truth, this is a re-birth. The essential characteristics of parenthood, therefore, were to Ferenczi the essential characteristics of the analyst. Clear understanding of oneself, depth of feeling and human kindness, humility, high imagination, great patience and endurance, fearlessness, a capability to learn and an ability to teach by example rather than by precept—these are as necessary elements in the analyst's capacity as is his carefully acquired skill. Sándor Ferenczi little knew, as he so painstakingly and with much opposition laboured at his psycho-analytical research, that these very characteristics summarized to a high degree his own rich personality.

CHILD DEPARTMENT CONSULTATIONS[1]

By D. W. WINNICOTT, London

My object in reading this paper is to report the cases that came through the Child Department of the Institute of Psycho-Analysis in London over a period of one year. What I have to say is therefore not directly analytic, though I think it is of interest to analysts.

One of the reasons why the Child Department was set up was to provide for the children brought to the Institute for consultation. It was easy to foresee the difficulties and disappointments which this part of the Child Department's work must entail, and which my description of this year's work clearly shows. These cases simply fall into line with the thousands of cases that also assail me in my position as Physician at a Children's Hospital.

Over a period of one year I took trouble over each case, and gave up time deliberately in order to do so, and in order to be able to give this report to the Society.

It will be understood that I am giving an account of the cases that were actually sent to the Child Department in the course of a year, and that I am not including an account of the cases given for analysis to Candidates, which were all taken from other sources.

Some cases never actually came for consultation. For instance, a doctor rang up about his little daughter aged 3½ who had recently started a bad stammer. She was an only child. It appeared that the child had become very attached to an aunt who had looked after her while her mother and father were away. Grief at the aunt's departure did not appear until the child's little girl friend also left the neighbourhood. She then became depressed and started the stammer.

[1] Read before the British Psycho-Analytical Society, June 3, 1942.

Enquiry showed that the child's emotional development had proceeded normally till these events, and the home appeared to be reasonably stable and loving. As the child lived too far away to come for analysis without the risk of her seriously tiring physically, I answered the father's query about analysis being necessary by saying that in my opinion it was normal for a child of 3½ to show violent symptoms, and that as his child's development was satisfactory in other respects the best course would be to ignore the symptom and not look to psycho-analysis for help at present. A week later the doctor again rang up, this time to say that the child's symptom had disappeared.

It will probably be agreed that it is wrong to extol the value that analysis would have, if applied, in a case where analysis is not applicable. Parents who come to consultation are feeling guilty about their child's symptom or illness, and the way in which the doctor behaves will determine whether they will calmly return to taking responsibility which they can well take, or anxiously hand over responsibility to the doctor or clinic. It is obviously better that the parents should retain such responsibility as they can bear, and especially is this true if analysis cannot be given a chance to lessen the actual illness of the child.

Case 1.[2] Ellen, aged 10 years, living in London. A first and only child. I could not get a good history in less than an hour and I could not avoid spending four separate hours on the case. Here are a few details.

It can be taken that this child was physically and emotionally and intellectually normal at one year. At that time, however, the mother left her husband and took the child away, after which the father only saw her at intervals. When the child was 6¼, the father arrived, unannounced, and picked his daughter up in his car as she was on her way to school. The child came away without a murmur, and was contented to be brought back to London. After this the father started divorce proceedings. When she was 9, the father remarried, this time making an excellent choice. The child's home background now became good for the first time since she was one year old.

The complaint was that Ellen was artificial. She was nice, and good, and intelligent. The only thing was that 'you could not get on to a sincere basis with her', as her father said. In addition, she was childish for her age and it was said that one could never predict from her mood on rising what might or might not happen in the course of the day. School reports showed ups and downs, and the reason for consultation was one incident of thieving which stood out as more than the common petty thieving of school children, perhaps because of the absence of shame. It was a fatal thing to arrange a treat specially for her. Whatever it was, or whoever arranged it, it failed because she became depressed or irritable. Her parents said that if she was caught off her guard she would usually be found to be sorrowful. Her real mother's moods were also unreliable.

Superficially the child was very happy with her father and especially with her excellent stepmother, to whom she clung. Yet it was easily found that she mourned the loss of her real mother, who had been anything but a satisfactory parent to her.

Analysis could not be arranged. One of the reasons for this was that no analyst capable of dealing with this case had a Clinic vacancy. This, I am afraid, will be a recurring theme. I was also influenced by the value to the child of keeping on at the school where she stole the chocolates, where she had some fairly good contacts, at any rate with the staff, and where she might still make good. She was still welcome there, though as a problem child. In a letter to the school I asked that the attempt to 'cure' her, to make her normal, should be abandoned: it should be considered good if major incidents were avoided.

A special problem arises in regard to the possibility of analysing a child of this sort. I have known and know of the analysis of highly suspicious children, but nothing can get away from the great danger of the child refusing to come for treatment at an early stage.

I have to hold myself in readiness to see this child again as new crises develop.

Similar suspicion marked *Case* 2. Norah, aged 13 years, living in London. Brought by her very intelligent sister because she refused to go to school. She was the youngest of several children.

I invited Norah to pay me a few visits. She came, and drew pictures. After two visits to me she wrote me the nicest possible letter stating that she did not wish to come any more. In this case I had refrained from interpreting, because I knew that if I succeeded in getting behind the suspicion at all I should have to go on with the analysis. And I was not in a position to do so.

Knowing the child's distress, I transferred her to the Paddington Green Children's Hospital and sent on her track Miss Norma Williams, who works with me there as Psychiatric Social Worker. Miss Williams was welcomed, and in many regular visits she made a better contact than I had made. Eventually Miss Williams, valued friend by now, came up against another version of the absolute barrier that I had met so quickly. For an analysis to have been carried out in this case, an analyst would no doubt have had to visit the child daily, and to do the first part of the analysis in the child's home and on walks and visits to museums. Naturally the Clinic does not cater for this, although many of us can draw on experiences of

[2] All case material has been modified to ensure that no child can be identified by the reader.

this kind, if we go over in our minds the unexpected things that have happened in our private practices.

The child gained considerable benefit from Miss Williams's visits, but she did not get back to school. She has now reached the school-leaving age. She has managed to take a holiday away from her home, and seems likely to start work.[3]

A wealth of hidden feeling and phantasy was discovered in the course of discussing well-known paintings and studying the child's own considerable artistic efforts, but this rich world of her phantasy was really a secret inner world, and she felt it dangerous to let even Miss Williams (who is skilled at not forcing friendships) do more than know of its existence.

In my experience, many of these adolescent children, who seem to be just failures at the time of consultation, come for help or even analysis when they are on their own, say at 18 or 20 years old; and apart from this, children who are attempting to manage the acute problems of early puberty can get value from support which comes from outside the family, especially when the family is itself in unstable equilibrium.

Case 3. Maisie, aged 3 years. This was an acute case. Maisie had developed extreme restlessness and seriously disturbing compulsive rocking movements and neurotic anxiety in connection with her mother being near the end of her second pregnancy. The new baby was over-due, and my contact with the child extended over the period up to the birth. Tension was greatly relieved by the actual event of the baby's birth. It would have been logical to have arranged analysis for this child at the end of that time, but no one could be found to undertake the onerous task of daily taking the child to and fro. Incidentally the child suffered severely from lack of anyone to take her out, even for a walk.

My only way of helping was to visit the child in her own home. I was given facilities for seeing the child alone, and I did not use toys. I found her to be maniacal almost to the degree of being inaccessible at first, but she heard and noted my interpretations, and came to value my visits.

Her play was clearly to do with the mastery of birth phantasies, and later of various phantasies dealing with the relation between the parents. In five visits spread over a fortnight I had a tremendous amount of material for interpretations, which I gave in the full sense of the word, making use of the transference from the beginning.

It is difficult to assess results. Naturally no permanent change in the child's personality was looked for, but I had the satisfaction of seeing the chaos of the child's phantasy world becoming organized and the maniacal behaviour developing into play, with a sequence in it, as in a satisfactory analysis. The phantasies were clearly expressed and dealt with many aspects of the child's anxiety over her mother's pregnancy, which seemed as if it would never end. Anxiety about harm to her mother was important. Much material dealt with the distinction between the bad man who puts her mother in such danger and the good man (her father was a doctor) who helps her out of danger.

Phantasies of incorporating the analyst were strong and had to do with her real need for me all the time.

The child was naturally relieved at the actual birth, and soon found a normal relation to the baby sister. She is still in need of analysis, and if someone could have been found to bring her to the Clinic, I should by now have arranged for her analysis by a Candidate. An acute case, but not necessarily very difficult.

Case 4, Tommy, aged 12 years, living in London, was unsatisfactory from my point of view. This boy came with a letter from the Institute for the Scientific Treatment of Delinquency. Could he be given psycho-analytic treatment? The answer was: no, because in order to get the boy for treatment someone or some group of people would have to be found to bring him daily from a very distant part of London. Further, he was a definitely psychotic case, schizophrenic in type, and therefore only suitable for research analysis by an experienced child-analyst; and no such person would be likely to have a vacancy for a free case. I mention this sort of detail over and over again, because it is no good our pretending to do what we cannot do. It is no good anyone asking us to consider a case if the address is in a remote district, unless there are exceptional facilities for travel, or if the child can attend on his own. And then, of course, there is hardly ever a vacancy. Further, if there is a vacancy, a candidate cannot be given so difficult a case as this one was certain to be.

That is why it is so futile to do consultation work, unless a wide view is taken of the duties of the consultant. I saw the mother and the boy, and this took me about an hour. The mother was very suspicious and the lack of useful outcome from the visit increased her grudge against all sorts of clinics and hospitals.

Case 5 was equally futile: Max, aged 9 years, living out of London. A refugee from Germany.

The parents of this child both had knowledge of analysis and, naturally, when they saw their child in distress they decided to have him analysed. Certainly the boy needed it, but to have had him analysed I should first have had to find a hostel or school where he could live. The parents had failed to see in advance that it would not be possible to overcome this difficulty, and I fear they were very much disappointed. If at any time in the distant

[3] Later: Norah is now at work, doing well. She appears to have successfully negotiated her difficult pubertal phase.

future we have quite a number of analysts doing child-analysis, we must try to get a small home set up where children of various ages could live a family life of sorts and get education, while being near the Clinic for analysis.

This boy had had many changes of physical background and he had reacted badly to each change. He was said to have no power of concentration, to be moody, to be suspicious of food and of children of his own age, and to be unloved. And then there was the matter of his being a Jew, this having hitherto been hidden from him. The parents badly wanted help for him. I wish they could get it. It took me well over an hour to take his history and to get the mother to realize I had nothing to offer her.

A little less unsatisfactory was *Case* 6. Tessa, aged 13 years. Living in the suburbs.

This girl's father rang up and asked for psycho-analysis for her, because she was not doing as well as he had hoped at school. In a short interview I formed the opinion that the girl was not psychiatrically ill. There were difficulties, including an unreasonable expectation on the part of her father. He wanted her to pull the family up by becoming a doctor, but she had no enthusiasm for this. I passed on the case to Mrs. Marion Milner, who went into details and gave advice about the schooling in the way she is fully trained to do. There was no vacancy at the time for analysis, and in any case it would have been impossible for the girl to stay at school and also travel up to the Clinic every day.[4]

The next case was entirely different: *Case* 7. Queenie, aged 3 years. Living in N. London.

Some friends of mine who are acquainted with psycho-analysis sent this child, the daughter of their charwoman, because she had started stealing. The mother brought her to treatment two or three times a week over a period of six months. This was quite a difficult thing for the mother to manage, and when her next pregnancy got under weigh the mother ceased bringing her. It was always clear that I could not reckon on daily visits in this case, nor could I expect to be allowed to give the treatment for long. However, I just went ahead, as if I were doing analysis, recognizing the limitations, but not wanting to send a child who had been brought to the Clinic away with nothing but a useless consultation.

As a matter of fact quite important work was done, for the material brought by the child enabled me to show sequence and order in it, and I obtained specific results from interpretations, just as in real analysis. The play with toys and by drawing and cutting enabled me to interpret and to show that I could tolerate penis envy and ideas of violent attacks on the mother's body and on the father's penis and on babies unborn. She told me of sexual play with her brother. The stealing stopped, and the mother, as so often happens, forgot that the child had ever stolen.

I would say that a real analysis had begun, and that sufficient work had been done on the child's reaction to week-ends and holidays, and so on, to enable her to deal with the end of the treatment when the visits could no longer be arranged. What I did, though it was not analysis, could only have been done by an analyst, experienced in long unhurried analysis, in which material can be allowed to force itself on the analyst's attention while he gradually learns to understand it.

Case 8 was a possible analytic case: Norris, aged 6 years. Living in the suburbs.

In this case both parents are doctors. The mother came and discussed the problems that had arisen in the boy's management, and this of course took us at least an hour. It appeared that the father had been timid all his life, and hoped to find in his son all the robust qualities he had missed in himself. He had married a wife who was very forceful indeed, and the only child of the marriage was a timid boy, almost exactly like his father. It became evident that the parents could both manage this child well if they could settle down to the idea that he was of a timid type. Actually the boy's passive-masochistic organization was near-pathological. I should have liked to have arranged analysis, and it is not yet certain that analysis is impracticable here. But although I am hoping to be able to send this case to an analyst, I find it bad to let the parents feel that analysis is their salvation. They must adjust themselves to the situation without thinking of analysis, which I shall only offer them when I know it is available. I mean that one must avoid giving the impression: 'Yes, psycho-analysis will cure him, that is to say, will make him as you want him, without any more effort on your part.' I have not yet seen the boy.

I am talking to myself here. At one time, in consultations, I always thought of psycho-analysis as the treatment of choice, and this led to my feeling I had done my bit if I had tried to bring psycho-analysis about. But consultations are of negative value unless analysis is kept completely out of the picture except in so far as it can definitely be arranged. If in addition to what is advised and to other benefits, psycho-analysis can be offered *and actually brought about*, so much the better.

The following case was definitely more satisfactory, though its satisfactoriness depended on my being able to do something immediately. I do not know how we shall one day solve this problem of always having a vacancy ready waiting. But

[4] On looking back I think this father intended to get into touch with the Institute of Industrial Psychology, but did not know its correct name.

white-hot material has a special interest of its own, and an analyst who never has room to take an acute case misses valuable experiences.

Case 9. Francis, aged 11. This boy was brought direct to the Clinic by his mother, who claimed urgent help. Francis was violent and in many ways pathological, and was also distressed about his own condition and often asking for help.

The original consultation with the mother in this case took 2 hours and was of great importance. For I found that there were two ill people in the case, the boy and his mother. There is a mass of interesting detail that could be given about this case, but to give it all here would be to overreach my present aim.

I would say that there is special interest in the way the boy's mania was related to his mother's depression: intolerance of her depression would make him maniacal. In order to help her I had to start her son's analysis immediately. The result of the first few weeks, in which he behaved like a restless adult and chose to lie on the couch rather than draw or play, was that he changed in his attitude to his real father. He recovered belief in him, following direct Œdipus interpretations of material supplied at white heat in terms of play with his sister. In his phantasy the sexual father was bad and did harm to his mother's body, so that the Gestapo were acting on his behalf when they took his father away by force, and he was strongly identified with them. He soon took me on as a good father, helpful but non-sexual, and asked me to see his mother sometimes, especially as she had seemed less depressed since I had come into their lives. It is noteworthy that he did not think of me as 'in love with mummy', which would have been according to his pattern with all the men he had liked before his analysis started.

Do not be disappointed when you hear that the mother's depression recovered so far that she arranged for the boy to go away to a boarding school. This in the circumstances was a real advance in the home situation, and meant that a father figure had returned to the home. The analysis is quite firmly planted. The boy comes to me whenever there is any holiday and makes use of analysis as fully as possible in the circumstances.

Case 10. Nellie, aged 17 years.

Nellie has a brother 2 years her junior. Her father had been a doctor, and he and his friends made a lot of her. But when she was 4 her father died, whereupon her mother and she and her brother moved to town and to an entirely different life, where the grown-ups were mostly women, and the boy was now the centre of interest. Perhaps the change of surroundings, coming on top of her father's death, was too much for her, for she stopped what till then had been a satisfactory intellectual and emotional development. At 16 she had an illness with persisting body movements, which some doctors diagnosed as chorea. Her own doctor, a friend of her late father, pronounced that this was not true chorea, because of the existence of obvious and long-standing psychological difficulties. On careful enquiry, however, I was bound to say that I regarded this as true chorea, which simplified my advice to the school. For it is easier to tell a teacher to allow for bad handwriting because of chorea than because of emotional hold-up. The main complaints, however, could not be ascribed to chorea, and included difficulty in making friends. The teacher wrote: 'There is a turning away from, instead of a turning out towards, in a way which is not the normal reserve of adolescence, nor just a characteristic of normal "introversion".' I saw this girl several times and she liked the interest of a new doctor; but she was terribly contented to be exactly as she was, and I did no good whatever in this case, except by pointing out that the girl was still in the convalescent stage of chorea.

Analysis could not be arranged in this case, and were an analyst willing to take her on I should advise him or her to do so only for research. At any rate this is no analysis for a Candidate.[5]

I give the following case because, although the girl is 20, she is clinically adolescent: *Case* 11. Nancy, aged 20. Living in London, billeted in a home county.

Nancy came to me with a *dossier* from her Teachers' Training College which it took me half an hour to read. I had to have long interviews with her mother and to read many letters from her, and I had to see the girl herself at intervals over a period of six months, perhaps ten times. Nancy's father had died when she was six, and her mother had devoted herself to the care of her two children. There is a clever, healthy brother of 17.

It might be said in two words that Nancy was a sweet and clean and beautifully dressed girl who was in a state of delayed adolescence. The atmosphere of her otherwise excellent home, as well as her internal difficulties, made it hard for her to take the next step in her development, which was to assert herself. The best thing she had done, psychiatrically speaking, was to kick the girl who was billeted with her, a fellow-student at a training college for teachers. This 'symptom' had become magnified into so great an affair that the school had decided that they could not recommend her as a teacher on account of it, unless I was willing to take the responsibility on myself. This I was willing to do. She was supposed to be dangerously impulsive—'might hit a child'!

[5] This girl writes to say that she has passed matric and is learning to be a masseuse. She seems to think her interviews with me had something to do with her improvement!

It was touch and go when the girl came to me whether she would withdraw for ever from impulsive aggression and get set upon the path that leads to some kind of break-down, or would bravely face the nastiness that is in this clean and carefully folded person just as it is in other people. I think I helped her to the latter course, but to do this I had to see her; and I also had to see her mother repeatedly, to keep her from writing vilifying letters in defence of her perfect offspring; and further I had to go personally and find her a billet, that is to say a billet that had nothing to do with the training college. For the officials in the training college (really quite an advanced institution) had fully made up their minds that the girl was dangerous. Actually she has the making of an exceptionally good teacher of tinies, if she can bear to hurt her mother by living away from her.[6]

Obviously a case for analysis, but I do no good by putting her on a waiting list. I have let her know that psycho-analysis exists, and I think that one day she will take a teaching job in London, and then apply for analysis. The tragedy is that at the moment when she applies, free psycho-analysis may not be available.

Here is a child who was able to get help from me although he could not come for analysis: *Case* 12. Keith, aged 3½ years. Living in the suburbs.

Sent to me by a relation who is a doctor friend of mine. This doctor is a bit of a psychologist, and he said it was clear to him that the child's mother (a non-Jewish girl who had married into a clannish Jewish household) was neglecting the child. After I had gone into the case, I felt that here was a clash between two methods of child-upbringing. The mother turned out to be badly in need of support. She immediately got some help through being allowed to give me the usual detailed case history, which I cannot take in less than an hour.

The boy was easy to feed at the breast (6 months) and was easy to train at first. Difficulties started at the introduction of solids. He was always forward intellectually. As a baby he was of the passive type, contented to lie and smile. He hardly ever cried, in contrast to his new brother (9 months) who is behaving quite ordinarily. Complaints were: Not sleeping, even with drugs. Screaming with rage, negativistic from 2 years. A continuous nuisance to feed, since beginning on solids. No guts in relation to other children, so that he turns any child into a bully. Cannot take 'no' for an answer. Also cannot be left alone with the baby, because of jealousy that did not appear till about 8 months after the baby's birth.

I saw this boy once a week, as analysis could not be arranged. As long as he could be brought, I acted with him exactly as if he were in analysis, and he brought material for analysis that had to do with the management, in his mind, of his father and mother. As a result of the work his relation to his mother improved, he became actually demonstrative with her and said 'I love you, I want to kiss you,' for the first time. He also started to sleep in a way which he had not done since he was 2, and he stood his father going into the army quite well. When his mother found it difficult to come any more, I supported her in the idea of leaving off treatment, because the alternative would have been to say to her husband's family that the child was needing more care than she could manage to give, which would have again undermined her confidence in herself.

If I had said that nothing could be done here except analysis I should have missed a good opportunity for therapeutics, and if I had confined my work to giving the mother advice I should have missed the main thing, which was the child's new ability to tell her he loved her, which came as a result of the treatment. The adverse external factor was the rather robust but not pathological homosexuality of the father, which this particular child could not stand till he had expressed his hostility to his father in play. He dramatized this with a toy figure, pretending to pull the figure out of his anus, and made a deliberate effort to get me to understand his meaning, naming the figure 'daddy'. He rid himself of the homosexual daddy in play, and then improved in his relations to his real father and mother.

I also helped the next girl a little: *Case* 13. Gertie, aged 17. Living in London.

This girl came from the head-mistress of a High School. It was reported that she had reached no satisfactory academic standard, that she had no beauty, no friends—in fact, she was said to be incredibly lonely. She could give lucid answers to questions, but she had speech difficulties. For a time she had had treatment at the Tavistock Clinic, but without result. All this came over the telephone from the school.

As usual I took a good hour to take a history from the mother, who had been successful in bringing up her son (who is 4 years older than Gertie). The mother was already nervy while carrying Gertie, and after the birth of the child she could not help worrying about her. She wished to wean her, but the G.P. (probably unwisely in this case) persuaded her to persevere with the breast, which she did for the full 9 months.

Early signs of intelligence appeared normally, so that the child cannot be said to be backward because of brain tissue defect. During the history-taking the mother remembered that at five the girl had hit her brother on the head and made him

[6] Later: Nancy has completed her college career without further trouble, and has started in a good post. Her defences are organizing into a tendency to explore spiritualism, for which there is strong precedent in her family.

bleed, and she thought this may have been a turning point. From about this time Gertie failed to develop at a normal pace intellectually. The family is a clever one.

The child told me she had 'doctor fright', and indeed she had seen plenty. We made the following list of things needing cure: pimples, tendency to fester, excessive sweating, being bad at exams., writing and speech clumsiness, difficulty over making friends, difficulty over knowing what work to do, and also her mother's hypochondriacal worrying.

What she seemed to need immediately was for a doctor to say firmly to her, in front of her mother, that she would be wise to see no more doctors. I did this. A month later she came to me to let me know that she had taken a job and was making friends and was beginning to feel more confident.

If I had put her on a waiting list for analysis, I should have been a bad doctor. I wish to be understood here. I believe that there is no therapy that is in any way comparable with analysis for this child. But as this could not be arranged the alternative was to do as I did, to act apart altogether from the existence of psycho-analysis, and *in this case* to put the girl off therapy of any kind.

The next case, *Case* 14, Cyril, aged 10 years, living in a home county, came to me from a doctor, following a visit from me to a Child Guidance Clinic.

This boy urgently needs help, and is conscious of this need. He could, however, only be analysed if there were a house where he could stay, and from which he could attend at the Clinic. I hope there will one day be such a house, because research on insane children can now be done as a result of the recent advances in psycho-analysis.

It took me an hour to get a good history of this case, and another hour to establish the contact with the boy which I needed to form a conclusion as to his intelligence, his emotional development, his illness, and his prognosis. And I have seen the boy a dozen times, because he implored me to do so, on account of the very great psychotic anxiety to which he is liable.

His trouble started with his difficult birth, which was a month delayed, so that he was a very big baby. He was born blue, and badly cut about. The doctor thought he was dead, but to his surprise the baby showed signs of life after having been abandoned. The doctor said: 'Well, you've got a baby, and he's going to give you a hell of a lot of trouble'—an accurate prognosis. At five he was pronounced mentally defective at a famous children's hospital. Actually he is not intellectually backward, but he is insane, and this interferes with his relationships. His school puts up with him as odd, and rather likes him.

He is liable to attacks of extreme terror with no external factor to account for them, and he has times of uncontrolled temper, and all sorts of insane ideas appear. For instance, he once came to me with a tank on his hands. By this I do not mean that he had a toy tank or that he had an idea of a tank in his head, I mean that he felt he really had a tank on his hands. He constantly tried to get it off, by squeezing his hands between his legs, passing his hands between his closely drawn thighs. He drew a picture of what he felt like. Also, for a long time, whenever he went to the lavatory to defæcate, a certain brick would seem to him to come out of the wall and wander round.

Further details of this case would be out of place here, but it seemed good to do something more than just see the boy in consultation. While I am seeing the boy (which at first I did weekly, though I can now increase the interval to a month), he is able to avoid giving trouble at school, and he has less severe attacks of panic. This is not because of anything specific that I do.

He is clever at carpentry and sewing, and loves the idea of farming. He studies aeroplanes in great detail from books, and shows signs of making an exceptionally interesting, restless adult with patchy brilliance.

My object has been, as I stated at the beginning, to report a series of consultations. There is nothing particularly interesting about the series except that it comprises all the cases sent to the Department over a period of time and presumably indicates the type of case to be expected if an attempt were made to widen the range of the Department.

It may be that some of this non-analytic material has proved of interest to analysts. It is a personal opinion of mine that it is to analysts and analysts only that non-analytic material is really interesting. For instance, when a mother gradually pieces together an almost complete history of her child's emotional development, who but an analyst can supply what she wants, which is the true recognition that all the pieces do weld together into a whole?

Also many odd flashes of insight from parent and child remind the analyst of material patiently acquired in analytic work. I would go further and say that I have learned much that is of value in analysis from the study of consultation and other non-analytic material.

One practical point emerges. The primary aim of consultation at the Institute, I take it, is the provision of suitable cases for Candidates, or for members who wish to go on to do child analysis. I have never expected that this aim would be achieved, and I think my fears have been justified by this report. It is a matter which we shall have to work out gradually, but it does seem to me possible that the proper place for seeking good cases for Candidates is a hospital clinic.

There are two possible points of view. According to one, we can encourage vast numbers of cases to

impinge on the Institute, and retain a percentage on the ground that they are suitable for training purposes, letting the rest fall off as their fingers tire and when they can no longer keep a hold on the waiting list, which is their one hope. The other is for someone to be all the time seeing and dealing with a large number of psychiatric cases of all kinds (as, for instance, can be said of my Paddington Green Children's Hospital Out-patient Clinic, and of the Maudsley Hospital clinics and others). From such departments, occasionally and as required, cases can be transferred for analysis.

In the case of children, it is possible that the second is actually the only possible method, for adults who bring the children are in most cases normal healthy adults; and if a child is simply put on a waiting list the adult goes elsewhere for advice. Even a fortnight's wait for consultation is usually enough to put a parent or guardian off. A series of children put on a waiting list and left there would be a constant source of ill-feeling, and would all the time be seriously interfering with the good relations of the Society to the external world.

As far as I can see it then, while it will remain necessary for someone to attend to the consultations at the Institute, as at present, it will continue to be necessary also to draw on another clinic for good analytical material for Candidates, especially as the best way to start teaching child analysis is to give an analyst a fairly normal little child of three.

It might not be out of place to give a list of conditions that have to be fulfilled when I am trying to supply a Candidate with a child. I have to find a child of the required sex and age, of the right diagnostic grouping and degree of illness, with a mother who is genuinely, yet not too hypochondriacally, concerned about the child's disorder, whose address is within easy reach of the Clinic, whose external circumstances allow the mother to give up two or three hours a day to one child, whose faith in her doctor will carry her over until the period when she begins to get encouragement from the changes in her child's symptoms, and whose financial status allows her to spend money every day on trains and 'buses.

If I or my personal clinic at hospital were to fail, it would be necessary for the Institute to get into touch with some outside pediatric or psychiatric clinic; at present nothing approaching what is required for training purposes is to be expected from the cases coming to the Clinic direct, and I am in doubt whether that should ever be our aim.

It will be felt that there is a note of frustration in my paper. I admit this. I am always wanting to arrange for the patient to be analysed, knowing well that nothing else that can be done approaches or can be compared with the results of analysis. At the same time I am acutely aware that analysis is very seldom both applicable and available. Often the patient cannot be brought to the Clinic, or too complex external circumstances would have to be managed, and usually when a case could be treated it is unsuitable for a Candidate. And it must be remembered that it is quite rare for even one new child to be required for analysis. I may go three months without being asked to supply a case.

My sense of frustration must therefore arouse your sympathy. It is clear that the only solution is for more analysts to exist and to proceed to child analysis. We all long for this, and we also know that it is just here that it is difficult to bring about changes, and that no good can come from hurry.

SOME OBSERVATIONS ON INDIVIDUAL REACTIONS TO AIR RAIDS

By MELITTA SCHMIDEBERG, London

It is interesting to compare the expectations of the probable effects of bombing with what later actually took place: the difference between imagination and reality is striking.

Most people entertained extravagant ideas. Some thought London would be bombed even before war was declared. The Government expected raids of greater intensity than those which actually occurred, but not that they would be so prolonged. It is said to have prepared tens of thousands of *papier mâché* coffins, but it had omitted to provide shelters to sleep in. According to Farson (1941; 7), experts predicted 30,000 to 35,000 casualties per day.[1]

Haldane (1938; 21), rightly considering fantastic Lord Halsbury's forecast that a single gas-bomb would kill everybody between the Thames and Regent's Park, assumed that 500 aeroplanes, carrying two tons of high explosive each, could kill about 20,000 people and that the 'knock-out blow' might kill 50,000 to 100,000 Londoners (*ibid*; 40, 63). He therefore believed that quite an extraordinary amount of courage [2] would be required for working during raids,[3] or even for

[1] I was given this figure from another source as well. I am told it was arrived at on the basis of statistical calculations from the number of persons killed from the air in the last war per ton of explosives.

[2] 'But the cumulative effect of a number of successive raids is terrific. Any brave man can stand one raid. To stand a number requires military discipline, mass heroism such as is found in Madrid, or a philosophy which makes it clear why these things happen, and why the final victory of fascism is impossible.' (Haldane, 1938; 57.)

[3] Haldane thinks it most unlikely that in England or in Germany workers would go on working during raids. In Spain it was possible, because the workers organized themselves 'on a democratic basis which has enabled them to stand up to suffering and danger which men organized on a capitalistic basis cannot stand.' (*Ibid*; 74.)

walking down the street without a respirator.[4] Haldane considered that, in the absence of organized evacuation, panic evacuation and the use of violence might result[5]: that popular fury might turn against the Air Raid Wardens,[6] who 'are being given an impossible task, and exposed to unnecessary dangers' and 'whose main function appears to be propaganda in favour of an unworkable scheme.' (*Ibid*; 252.) Others voiced fears of epidemics. Lloyd's statement, quoted with approval by Haldane, makes curious reading to-day: 'The one subject on which he found complete unanimity amongst the air raid precaution experts in Germany, France and this country was the great value of trenches as air raid protection.' (*Ibid*; 206.) Travelling every week for some months, invariably whilst a raid was in progress, I used to read with interest the notice in the train, advising us to lie on the floor when a raid was in progress (since then altered to 'when danger is imminent'). Langdon-Davies (1938) saw the greatest danger in panic, an opinion apparently shared by many psychiatrists. Mental wards were emptied in expectation of overwhelming numbers of shell-shock cases. The opinion had been expressed that the self-controlled English might not stand up to the raids as well as the Spaniards, who are more able to abreact immediately.[7]

Things looked very different when the blitz actually came. This country was not seriously bombed until almost a year after the declaration of war.[8] The casualties were very much fewer than had been expected: official statistics given in *Front Line* (1942; 158) show that up till the end of 1941 some 190,000 bombs were dropped in Great Britain, killing 43,667 civilians. But the raids were very much more prolonged and sustained than anybody had imagined: by the end of May, 1941, over a million houses had been damaged in the London Region (*ibid*; 73). Yet by no effort of exhortation and propaganda did the Government succeed in persuading more than a fraction of the population to carry their gas-masks, and some of these law-abiding citizens did so because in the early phases they would not otherwise have gained admission to the cinema. Those who omitted to carry them may have felt guilty for not obeying instructions, but it did not occur to anybody that by so doing he was showing any remarkable courage. There was no difficulty in persuading people to work, once the authorities allowed it, nor to extinguish fire-bombs.[9] Since the call-up of women as fire-watchers the joke has become current that 'woman's place is no longer in the home but on the roof'. The population of London certainly stood up to the blitz better than the Spaniards, if we can trust the descriptions published. But we may hope that the descriptions were at fault. There was certainly no panic evacuation on a big scale. Though the Government organized the evacuation, paid the fares (often more than once), found the billets (again often more than once), and used every possible method of appeal to the parents to send their children to the country, in October, 1940, there weres till 125,000 school-children (25 per cent.) in London. By sending house-to-house visitors, personally known to the families, it eventually became possible to reduce this number to 80,000 (Calder, 1941 a; 60).[10] Since much publicity was given to conditions in public shelters, it should be stressed that the number of those sheltering in them was very small indeed compared with the number of those who went on sleeping in their houses or in private shelters.[11]

Contrary to Haldane's (1938; 129) forecast that 'when people realize that ordinary houses offer no serious protection against bombardment the wardens will inevitably lose any prestige which they may possess', the standing of the Air Raid Wardens could not have been higher. They were the fathers of the population, to whom people turned in emergencies of every sort. If they did

[4] 'If you are sufficiently brave . . . you may be brave enough to walk to and fro in the streets during an air raid without a respirator.' (*Ibid*; 245.)

[5] 'Any family with £5 to spare and a relative in the country will hire a car to save their children's lives. There will be an appalling chaos on the main roads out of London. . . . The sight of this traffic stream will arouse intense resentment in those whose children are left behind. . . . There may be actual violence. Some mothers may commandeer places in cars for their children, even if Fido has to run behind. . . . Those who are not so fortunate as to have the means of escape will be filled with a not unjustified resentment. They will furnish the raw material for panic and rioting which the Government rightly wish to avoid. If I believed the stories of Bolshevik plots I should almost be tempted to believe that these instructions [for voluntary evacuation] were the result of one . . . to ensure on the one hand a massacre of the rich, and on the other an intense feeling of resentment among the poor.' (*Ibid*; 80 f.)

[6] 'It is stated in some quarters that the Raid Wardens . . . will be used as an organization for bullying the people in various ways. . . . If so it is also perfectly possible that some of the fury which in Spain was directed against the fascists after air raids, and which led to some of the very few murders of innocent people which occurred on the Government side, may be turned against the Raid Wardens in this country.' (*Ibid*; 129 f. See also 198.)

[7] Professor Mira expressed this opinion at a meeting of the British Psycho-Analytical Society in 1938.

[8] The first siren was sounded simultaneously with Mr. Chamberlain's declaration of war. A friendly aeroplane had been mistaken for an enemy one.

[9] Before the official distinction between 'alarm' and 'alert' had been made, the authorities found it necessary to warn workers that if they worked during raids they would not receive compensation for injuries. Many resented having to interrupt their work and to go to shelter. A man was fined for removing a time-bomb from his premises without permission.

[10] According to *Front Line* (1942; 66), by the end of September half the children were in reception areas, by the end of October 70 per cent., and by the end of the year over 83 per cent.

[11] The average number sheltering in London Tube Stations daily varied in the months between January and June, 1941, between 88,000 and 50,000 according to official statistics. *Front Line* (1942; 68) states that in November, 1940, of every hundred Londoners in the central areas, 9 were in public shelters, 27 in private shelters, and 64 in their own beds or on duty.

not know where to leave the baby, they parked it at the Wardens' Post.

In the hospitals doctors idly waited for the rush of shell-shock cases which did not come. Eventually they resigned themselves to filling the wards once more with ordinary patients. True, as time goes on we shall probably discover more cases of 'raid-shock'. But even making very generous allowances for the cases which have escaped notice, the proportion of these is negligible in comparison with the number of those who went through the London blitz unscathed.

As subsequent events have proved, the fear of raids had been greatly exaggerated.[12] This incongruity between expectation and actual events is the more remarkable, as the raids were undertaken under conditions more serious for Britain than anybody would have anticipated—from the coasts of the Low Countries and France. This exaggerated fear of air raids was probably of great political importance. It is possible that, but for it, the danger of war would have been faced earlier and better. Thus it is worth while paying some attention to the factors responsible for these fears.

It is obviously difficult to assess correctly a hitherto unknown danger, and the less we know, the more is the imagination allowed free play: sadistic ideas and anxiety may sweep away reason, or, what is worse, claim to be reason itself. The fantastic expectations seem to have arisen largely from three sources: (*a*) German boasts and threats; (*b*) pacifist warnings and fears; (*c*) certain reports of the Spanish Civil War.

The pacifists tried to make people peace-loving by frightening them with the dangers of war. Their gloomy forecasts that the next war would destroy civilization altogether were akin—as Glover (1933) has pointed out—to schizophrenic ideas of the end of the world. Yet it is remarkable that they helped the purpose of the Germans so well. Pacifists are people who have repressed their sadism to an exaggerated degree: hence they are over-sensitive to the idea of destruction and killing and (at least this is true of many of them) pathologically frightened of being killed. Yet the repressed sadism comes out indirectly against their own countrymen: they preached disarmament in the first place to their fellow citizens, instead of—where preaching was more needed—to the Nazis. They were so much pre-occupied with seeing the mote of British shortcomings that they had no time to pay attention to the beam in Nazi eyes. Their attempts to upset others by the horror of things to come had an undeniably sadistic flavour. Their unconscious hostility towards the British linked them with the enemies of their country. Then there were certain Leftists, who, though by no means pacifists, fell into Hitler's trap whilst trying to fight him; they were unduly impressed by his might and by the horror of the coming war and spread fear in their own country by their warnings. Many of them had, as it seems to me, particularly intense unconscious conflicts over sadism and a more than ambivalent attitude towards their own Government.

The reports of the Spanish War came almost entirely from Leftist writers. To judge from their description, it seemed as though the Spaniards must have stood up to the raids (which were much milder and less continuous than those upon London) badly. As these writers were full of admiration for the bravery of the Republicans, readers were bound to gain the impression that, if even the brave Spaniards were so frightened, then the dangers must indeed be terrible. After three days raiding of Barcelona, Langdon-Davies (1938; 15) was 'unable to find anyone who did not frankly admit that he was reduced to a state of impotent terror by the end of the period, and careful observers went so far as to suggest that had the technique been used for another forty-eight hours there would have been a total paralysis of the life of the city and of the power to resist. By the third day the city was in physical flight.' 'One man who stood for five hours in a queue for the station said: "As two hours passed from the last raid I began to be sick with terror. There we were, near a 'military objective', the Station, and the time had come for the next raid. I tried to steady myself by thinking. 'If they come, many will run for shelter, and then I shall have a better chance of getting a ticket.' But, of course, if they had come I would have found myself running, too"' (*ibid*; 45 f.). 'One cool and experienced observer admitted that "When they began to drop all round here I couldn't stick it any longer and went up to such and such a place." Actually no bomb dropped within a mile of him' (*ibid*; 84 f.). Langdon-Davies (*ibid*; 118) quotes the description of a shelter marshal: '"About five hundred come into my refuge, mostly women, old people and children. Many of them, terrified by the explosions, won't leave again for hours. Sometimes a family comes in and at once misses one of the children. Nobody knows where it is. In the dark street outside you can hear people shouting anxiously, trying to find their way."' '"From below me in the refuge I hear children crying, everyone complaining."' (See also *ibid*; 94 f., 107 f., 111.) Again: '"Suddenly we heard explosions and at once the anti-aircraft guns opened up. At the same moment panic broke loose as the people scattered crazily in all directions, plunging into doorways, falling over and over. Four or five thousand metres high appeared three or four aluminium coloured planes. They seemed to be directly overhead. I saw a

[12] The concentrated, four-figure raids of the R.A.F. have more resemblance to the picture of what was apprehended, but even they are far from producing the destruction prophesied in some quarters during the years before the war.

group of people who had run up a small alleyway bordered by two high walls. They pressed themselves against these walls. They sprang from one side to the other in the crazy belief that the wall opposite would give more protection than the one they had left. . . . Some continued running down the alley. They were running away from bombers who were speeding along at three hundred miles an hour"' (*ibid*; 138 f.). '. . . Three people of very different stations all agree in describing their experiences as reminding them of the end of the world' (*ibid*; 124 n.).

Haldane (1938; 286) states that Langdon-Davies over-estimates the psychological effect of the raids.[13] Yet his own pronouncement, 'I prefer 60 feet of earth to any amount of work as an antidote to fear' (*ibid*; 292), does not sound exactly encouraging. According to his own version: 'These raids succeeded . . . in creating a panic. About a quarter of the population ran out into the country. . . . Others lost their heads completely, and tried to dig holes in the streets. . . . The panic which occurred was partial. The Government kept its head, and there was no threat of a revolution to end the war.' (*Ibid*; 55.)

The raids that are supposed to have produced these panic reactions lasted from March 16th to 18th, 1938. In these three days 13 daylight raids occurred. The casualties have been given (by different observers) as 3,000, 912 or 1,300 killed. According to Haldane altogether 41 tons of bombs were dropped and in none of the raids did more than nine bombing aeroplanes take part.

Professor Mira (1939), the Chief Psychiatrist of Republican Spain, states that the reports current in this country concerning the raids in Spain were exaggerated. In thirty months 250 raids were made on Barcelona; 4,357 persons were killed, about as many as would be killed in peace time during the same period through traffic accidents. He claims that the psychological reaction to starvation was stronger than to bombs.

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When, before the outbreak of war, people tried to foretell the reactions of the population to raids, they were largely influenced by observations made on soldiers. But the psychological situation of the civilian population is obviously different from that of the Army. It seems that a number of cases of shell-shock were a reaction not to danger but to discipline (in particular with latent passive homosexuals). Again, soldiers derived a greater 'secondary gain' from shell-shock. They could escape an unbearable situation—whether of danger or discipline—only by breaking down. Civilians stayed in London of their own free will, often in defiance of Government injunctions. To become a neurotic casualty offered no advantages: it would have meant being sent to hospital; and hospitals were known to be particularly vulnerable. Hits on hospitals were always given publicity. Soldiers have a high ideal to live up to. Many civilians tried to be like them; still, they could more easily admit fear. On the other hand, being part of the Army, wearing uniform, having leaders to fall back upon, being told what to do—these are helps which civilians have to forgo, though the Civil Defence Services tried to provide a substitute. Many Londoners suffered most from the feeling of utter helplessness and the inability to hit back. Here too soldiers have an advantage: On the other hand, some soldiers break down, not as a reaction to danger, but because they are unable to bear the unconscious conflicts over killing. Civilians have no such burden of guilt. They are innocently attacked.

Londoners continued more or less with their normal lives. Soldiers often break down, not because of the fighting or the danger, but because of the accumulation of petty suffering[14]—exhaustion, dirt, cold, vermin and hunger. Yet in many Londoners a tendency to renounce pleasure and convenience as a sort of sacrifice could be observed, indicating that these very sufferings (so long as they do not become extreme) might in the case of some soldiers mitigate their unconscious guilt and thus prove a stabilizing factor. Soldiers in the trenches have to renounce sexual life. In some of my patients sexual frustration, in others (or sometimes in the same individual in alternate periods) guilt over sexual satisfaction, increased the anxiety-preparedness in their reaction to raids. It will depend on the individual which of these two factors is more likely to play a part in bringing about a break-down.

Londoners could at least enjoy some sort of family life, but they paid for it by additional concern for their families. In the last war soldiers at least had the reassurance of knowing that their relatives and their property were safe.

It does not seem to me possible to assess which is the more difficult of two psychological situations by adding up the advantages and disadvantages on each side. They are different settings with specific aspects, to which different people are bound to react differently, according to their particular sore spots. An individual who broke down in the Armed Forces might have stood up well to the blitz as a civilian, and *vice versâ*.

It has been suggested that the lack of 'raid-shock' cases can be explained by the fact that the average Londoner was less exposed to danger than the soldier in the front line. This is doubtless true,

[13] Neither he nor Langdon-Davies were in Barcelona during the raids in question.

[14] This point and various others were made by Walter Schmideberg during the discussions of the British Psycho-Analytical Society in 1938 and 1939. He was at that time among the few to insist that both the actual and the psychological effects of air raids were much exaggerated.

but cases of shell-shock among soldiers have often not been due to excessive danger. Indeed, some (e.g. Freud, 1920; 9, 39) hold the view that soldiers who have been wounded are generally less likely to break down mentally—presumably because their injuries have helped to alleviate their sense of guilt. The apprehension of danger and of suspense, with its mixture of realistic and imaginary anxieties, is probably a more important source of trouble than the danger itself.[15]

There are cities in Britain which have perhaps suffered proportionately more heavily than London, but none had to withstand such a regular assault. It is true that the majority of the inhabitants escaped injury and the distress of losing near relatives or their homes. But all endured the daily and nightly suspense for a number of months and there were few who did not have 'very narrow escapes'. Knowing full well that almost two hundred of their number were doomed to be killed every night,[16] as many or more to be seriously wounded, many more to be slightly injured or to lose their homes, they continued to sleep in their houses or shelters, which they knew to be unsafe, and yet—they slept. The danger, or its apprehension, was sufficient to induce a number to go to the very great inconvenience of evacuation or of sleeping outside London, an arrangement entailing sometimes some four hours' daily travelling. Why is it that the great majority could stay where they were and continue a more or less normal life? The fact that only comparatively few people broke down does not prove that the stimulus was negligible but that powerful psychological factors were working in favour of mental stability.

The same problem arises in relation to soldiers: it is not enough to analyse cases of shell-shock, we must also enquire how the average soldier manages to face danger, frustration and suspense without suffering ill effects as a result of these experiences—in other words we must investigate the sociologico-psychological mechanisms which are responsible for morale and resilience.

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This paper is based mainly on the observation of the day to day reactions (or the lack of them) of my ordinary patients, who had started analysis in pre-blitz times for reasons unconnected with the war.

The fear of air raids is a realistic fear, although it may be intensified by irrational anxieties. By realistic fear I mean both the objectively justified apprehension of impending danger, i.e. the next bomb, and the 'instinctive' reaction to the actual shock of an explosion, the visual or acoustic stimuli, the compression of air, vibration, etc. Whereas some people seem to have been most affected by various acoustic stimuli,[17] others were more sensitive to the vibration [18] and compression of air. People came to be able to discriminate as to whether a building was shaking vertically or horizontally as the result of blast. The intensity of the vibration felt depended upon the size and explosive power of the bomb, the distance at which it fell, etc., but it would be more noticeable on an upper storey than on the ground floor.

An Air Raid Warden told me that for a time he did not mind the raids, but that when he had seen the dead bodies of the victims and witnessed some gruesome incidents he visualized the reality of the situation and became thoroughly alarmed. The majority of the population only saw damaged buildings and bomb-craters, heard of people being killed or injured but did not actually see the casualties. Thus many lived through the blitz without fully appreciating the realities of the situation. Though the danger was real enough, the ideas generally formed about it were often unrealistic, especially during its early stages. They were based on things heard and read, part rumour, part fact. People's anxiety was stimulated not so much by bombs as by their informants. Some people were adepts at upsetting other members of the community: they simply radiated panic. One of their favourite devices was to depict comparative freedom from anxiety as stupidity or lack of imagination and to regard their own anxiety as an expression of superior knowledge or of a greater sense of reality. 'There are still people naïve enough to suppose' or 'imagination can scarcely conceive' rarely failed to produce an effect, if uttered with sufficient conviction. Rumours gained currency, masquerading as 'inside information'. The novelty of the information only went to show how secret it was. Some persons were more credulous than others. Their suggestibility was favoured by lack of knowledge and based on latent anxieties, but it was also influenced by their personal relation to the scaremonger. Often their original reaction towards these warnings took the form of satisfaction at their own superior fearlessness. But if this initial sense of triumph gave rise to guilt, they would then react with excessive anxiety, by way of overcompensation. The fact that none of us really knew what raids would be like helped the scaremonger to impress the more gullible of his com-

[15] Langdon-Davies (1938; 92) calculates that the 13 air-raids from March 16–18, 1938, which produced general panic in Barcelona, consisted of 13 two-minute periods of danger and terror; some 9 hours of fear without danger (alarm but no bombs) and 36 hours of growing suspense. If we apply this test to London, we shall find that between September 7, 1940 and May, 1941, there was an average period each night of 8–12 hours of fear (and in most districts of danger) and of 12–16 hours of suspense daily.

[16] The maximum number killed in one night (on May 10th, 1941) was 1,436 (*Front Line*, 1942; 22).

[17] The psychological importance of noise, and in particular its cumulative effect, has been stressed by Langdon-Davies, Walter Schmideberg and others.

[18] In my opinion analysts do not pay sufficient attention to vibratory sensations.

patriots with his predictions. After some weeks of the blitz, when people had had their own experiences and so could form a proper opinion, they generally became less suggestible.

The individual reaction to danger and mental strain was largely determined by the mental and physical conditions. In particular, over-tiredness and lack of sleep tended to undermine resistance. The cumulative effect of successive shocks was an important factor. A rapid succession of 'near escapes' proved more disturbing than would have been the case if the individual had had time to recuperate. In the early days of the blitz, when people were in a communicative mood, an elderly man spoke to me in an omnibus and told me of his escape, adding: 'I'm not quite ready yet for the next shock; I don't mind being bombed out again in a fortnight, but I want a few days to recover.' Conscious worries and anxieties had an important bearing on people's resistance. It was remarkable how much their reactions to the raids and to the war in general were influenced by their financial position, and how, for example, they would become more optimistic when their earnings increased.

Another important factor was the attitude of those with whom one spent the period of alert. Many people were more affected by a mild raid when in anxious company than by a severe one when alone or among cheerful companions. As a rule, people who were not too readily frightened drew strength from the fearlessness of others. If the disparity of reaction was too marked, the panic-stricken would often round on their more courageous fellows and accuse them of being unreasonable.

A Merchant Navy officer, who later had a nervous breakdown, told me that he was able to cope with his own fears, but felt it too much of a strain to have to deal with the anxieties of others, which he sensed even when they were latent. He was very good at handling people, and the more excitable others became, the more imperturbable did he appear. But it wore him out. This man was generally hypersensitive to the moods of others, partly because his own were so unstable, partly because he over-compensated for an initial feeling of indifference or contempt for their apprehensions. His mother suffered from marked changes of mood. However, this officer was in a rather different position from that of the ordinary citizen: he had to set an example. Glover (1942; 27) also regards responsibility for others (e.g. for young children) as a precipitating factor.

Yet in other cases such responsibility has a stabilizing effect. Many people have told me that when they had to look after others their fears diminished. A patient described how he had woken up one night in a state of anxiety when some bombs fell very close by, and the droning of aeroplanes seemed to fill the sky. A few moments later his wife also woke up very frightened. He reassured her and as he did so his own fears vanished. Three considerations may help to explain this phenomenon. The distress most people experienced during the raids was largely due to a feeling of utter helplessness. By helping and comforting others, they ceased to feel like a helpless child and assumed an adult rôle. They managed to 'project' the frightened part of themselves on to others and so to keep it at a distance from themselves. Looking after others strengthened libidinal ties, on which, more than on anything else, their mental resistance to the danger situation depended.

I believe that it is generally accepted that non-neurotic children were on the whole little affected by raids, unless they were injured or lost their relations, so long as the adults in their immediate environment remained unafraid. (See, for instance, Glover, 1942, 33, 37.) They reacted more to underlying anxiety in the latter than to their manifest attitudes. This applied equally to infant children and to domestic animals.[19] An experienced mother wrote to the papers suggesting that a mother should not nurse her baby in her arms when she felt frightened, but on a cushion: thus anxiety would be less easily transmitted. I was told of the following observation. A mother used to continue pushing her baby in its perambulator when a warning sounded or a bomb fell, but she would become visibly tense and after a while the baby would suddenly wake up crying. The mother had transmitted her feelings by the way in which she pushed the perambulator.[20] The observer compared this case with that of another family who obviously did not mind the raids, and where neither parents nor children displayed any reaction.

Apart from the moods of other people, one's emotional relation to them was important. Some preferred the company of men, or of women, or of a certain class or character. Some felt safer with their family, others away from it. Unconscious hostility towards one's wife might give rise to a wish that she should be killed, but this in turn would be likely to engender fears of suffering a like fate.[21] Conflicts over latent homosexuality might make the company of other men intolerable. Many could not bear the idea of being alone in a raid. Their attitude was often rationalized as a fear that there might be nobody to rescue them if they were buried, but it was, as a rule, largely influenced by some infantile fear of being left alone or shut in. (I shall return later to the importance of claustrophobic fears.)

[19] As a matter of curiosity I may mention that my cat seems, to judge by her behaviour, to have mistaken the sirens for the call of a tomcat.

[20] This again indicates the importance of vibratory impressions.

[21] Here is an analogy. A little girl told me she would like a witch to come and fetch her brother, but she was afraid the witch might make a mistake and take her instead.

Again, people reacted differently to the evacuation of those they loved. Many felt relieved of anxiety and worry, knowing that their family was safe in the country. Others felt neglected and deserted. Unconscious conflicts complicated the picture. A husband's guilt over his unconscious satisfaction at being rid of his wife and the desire to take advantage of her absence might make him feel unable to get on without her. People were usually glad to see others in the streets. In particular, shop assistants, park keepers and others who were compelled to remain in London by the nature of their work or for economic reasons felt relieved at the continued presence in the capital of many who had the means and the opportunity of going away. I do not remember ever having been welcomed with such pleasure in shops as during the worst weeks of the blitz. The sense of being deserted was often aggravated by the following mechanism. In order to avoid feeling resentful or contemptuous of people whose society or protection one needed (e.g. wealthy customers, one's doctor, etc.), one made excuses for them by stressing the dangers of living in London. Having thus magnified the dangers, one's fear of them increased. The fears aroused by air raids could often be reduced by making the subject conscious of his feelings of resentment and contempt.

I find it impossible to generalize about the question whether those who freely expressed their anxiety or anger over the bombing were better able to endure the ordeal to which they were exposed. Sometimes this was the case. On the other hand, many who displayed remarkable self-control managed very well. One came across people who gave an impression of being quite ill with fright but who claimed that they were free from anxiety. Others, terrified after a heavy raid, recovered from the shock in a few days or hours and then stood up well to subsequent raids. Different people have different ways of dealing with similar experiences.

For many people the sirens symbolized the angry or scolding voices of their parents, the raids the physical punishment which followed. One patient obeyed the warning slowly, reluctantly, in a disgruntled manner, precisely as he once used to answer a summons from his parents. In the early daylight raids one would often see people running in the streets while the sirens were wailing and then walking quietly again after they had stopped.

In the Hampstead Nursery (Burlingham and Freud, 1942 b) a boy aged 3½ complained that 'the sirens are eating me up'. The editors remark that some adults too are reminded by the sirens of the howling of a wild animal. Many people, even before the raids began, had, in anticipation of them, become unduly sensitive to every sudden sound. The sirens stirred up any phobias of noise. On the other hand, fear of raids was displaced on to the sirens or modified into criticism of their acoustic qualities. A blatant example of over-compensation was afforded by a person who described the sound of the sirens as 'lovely'. Another one claimed that they had a certain 'beauty' of their own. He thought that an admiration for their colossal penetrating power perhaps accounted for the feeling.

All analysts are familiar with the idea that a situation of danger revives fears of castration, mutilation, of being raped, beaten or soiled, while the picture of being buried alive activates claustrophobic reactions. The situation of being attacked from above and of being unable to retaliate resembles that of a small child whom an adult can strike from above and whose only resource is flight. A boy of sixteen told me, when the daylight raids started in August, 1940, that he experienced uncontrollable panic whenever he heard the sirens. If he was in the company of someone he liked, he felt all right. I asked him whether he had ever felt like that before. He admitted that he had when he was caught masturbating with other boys and was publicly beaten in front of the whole school (in Ireland). After a few weeks his fear had diminished to such an extent that he was able to sleep through the raids in his room on the top floor, and derived much satisfaction from feeling less frightened than other people. In the spring of 1941 he volunteered for the R.A.F. as an electrician, giving his age as eighteen. He is now abroad and doing well. A Merchant Navy officer who had never been on a torpedoed ship listened to the stories of those who had with the same mixture of anxiety, fascination, admiration and curiosity which he had experienced as a boy when he had watched others being beaten and used to wonder how he would face the situation himself.

Damage to one's possessions and home, or even to one's street and town, unconsciously signified an attack on one's own body and re-activated sadistic and masochistic phantasies. Sometimes, again, it signified being soiled and might then be accompanied by feelings of shame. One woman whose house was damaged by blast had everything cleaned, and, even after the cleaning was done, felt depressed for weeks and went on apologizing, as though she had been a child who had just wetted or dirtied herself.[22] Another reacted to the same

[22] Williams (in Glover, 1942; 23) comments on the 'docility to requests which seems a noticeable feature of victims of bombing'. Quite apart from the ingrained humility of many members of the poorer classes, being bombed was felt as a repetition of parental punishments and often produced a similar reaction of docility. Since punishment followed, there must have been a crime; therefore guilt and submission were appropriate reactions. Punishment produces its effects largely (see M. Schmideberg, 1931) by activating anxiety and aggressiveness simultaneously. The sudden overwhelming increase of hostility is dealt with by intensified repression, leading to submission.

situation with querulous complaints about the ruin done to her 'lovely things'. Needless to say the first woman suffered from a tendency to depression and over-sensitiveness, although she was not ill in a clinical sense, while the other was of a 'querulous' type.[23] Another said to me, as we were driving through the streets of London: 'I do hope all this will be cleared away before our people come back from overseas.' But the more common reaction was to take pride in and even to boast of unfortunate experiences, just as children sometimes brag about their injuries. People were eager to establish that they had had more bombs, bigger bombs and closer bombs than their friends. Some newspapers even started minor campaigns against the 'bomb bore'. When some houses in my street were hit, a patient admitted that she felt envious. 'Think how it would impress John!' Her lover, though he had seen some fighting in France, only came reluctantly to London and admired her tremendously for her bravery.

The awful things that happen in the darkness of the night symbolize sadistic intercourse between the parents. Two things are kept from children brought up in sheltered circumstances: the knowledge of sex and of death. We are all familiar with the sexual symbolism of death and shall not be surprised to learn that curiosity is shifted from the one to the other. A Warden told me that he had an irresistible urge to inspect dead bodies. There was an element of triumph in this curiosity: 'I am still alive.' A nurse reported a similar reaction when her patients died. In her case the satisfaction was overshadowed by worry and fear that a like fate might befall her too as a punishment for her triumph. Air raids revived childish fears of the dark, of noise, tempest and fire. People who had suffered from such phobias in their childhood were usually at a disadvantage during the raids. One of my patients, a simple woman, told me that her soldier son was the only member of the family who really minded the raids. 'He can't help it, poor boy,' she said, 'he used to be so terrified in the dark. He always complained that he couldn't see in the dark and was afraid of going blind.'

The variety of ways in which different people react to the same situation is due to a number of factors, such as the clinical type to which each belongs and the pattern of his or her reactions; the unconscious significance of the situation itself, earlier experiences, both before and since the war (illnesses, previous bombing, etc.); current factors, whether arising out of the war (e.g. evacuation, financial changes, sexual frustration) or independent of it (e.g. marital and family situation). A man told me that he did not mind being in a raid when he was outside London. There it was not his responsibility. On the other hand, according to the observations of Dr. R. A. Macdonald, some people felt safer in their own homes than away, even if the actual danger was greater.

Those who had to stay in London because of their work were sometimes more at ease than those who chose to stay of their own free will. The latter felt a heavier sense of responsibility—they were afraid not only of being hit but of being blamed if they were hit. This anxiety was stimulated by anxious relatives as well as by propagandists who urged them to leave London; it also reproduced a young child's fear that if he stumbled he would not only fall and hurt himself, but would be scolded or spanked into the bargain. The destruction of the Café de Paris and other places of amusement, including many public houses, was interpreted as a punishment for enjoyment and sexual life. A patient felt guilty for staying in London without any very compelling reason. She had decided to remain because of the presence of her lover, her analysis, a voluntary war job, and because the alternative was living with her parents. But she could not advance any of these reasons to her mother. If she were injured, her mother's reproaches against her for being unreasonable would be justified. Thus, the guilt she felt over her sexual activities, leading her own life and taking up analysis, increased her fears of the raids. Before the war, contact with her parents almost always had an unfavourable effect; her feelings towards her parents and her guilt over sex had become inextricably interwoven with her reactions to the raids. A man was rather upset when there was a raid on the place where he was spending his holidays. He told me that he would not have been so upset if he had not felt guilty for taking holidays. Raids were frequently felt to be punishments. A patient who had shown surprisingly little fear of the raids suddenly became anxious. It turned out that she had written a disagreeable letter to her mother and now feared retaliation. Her fear of raids disappeared as soon as this was explained to her. Anxieties which in time of peace would have been present without ideational content, or openly unreasonable anxieties, are now rationalized as air raid fears. In several cases sexual frustration was responsible for a greater readiness for anxiety. The patient reacted less to raids when she had a happy sex life, though in other cases again guilt over sex intensified the reaction to the raid.

Recently there was again an alert in London. Next day one patient said to me: 'Did you hear the sirens last night? There was gunfire and the sound of aeroplanes. Oh! I felt so nostalgic! It reminded me of the blitz time. I was so happy with John then. All the week I only hoped I should survive till Saturday, so that I should be able to go away with John for the week-end.' (They have parted since.) Another patient told me on the same occasion that she felt very upset when she heard the sirens: it brought back the

[23] Again, this querulousness constituted a typical reaction in many cases. (See Glover, 1942; 28.)

bad times of the blitz when she had been unhappy with her lover. Burlingham and Freud (1942 a ; 27) describe how children who lost their fathers in raids were forced by the recurrence of the raids to remember and re-live their former experience. ' For them every bomb that falls is one like the one that killed the father and is feared as such.' A patient who had stood up to the raids quite well was very much upset by a particularly severe one in May, 1941. Looking out of her window, she had seen a positive sea of flames. As a child she had suffered from a phobia of fire. The caretaker, for whom she had a great respect on account of his confident demeanour and of his having served in the last war, kept on repeating : ' We're the target.' This greatly alarmed her. It was generally believed that the Germans after having started a fire came back to drop their high explosives into it. She did not realize how many other fires were burning in London at that time, but thought her own neighbourhood particularly conspicuous. Her husband was more than usually nervous, because he had had a very narrow escape in the previous raid. The patient knew that as it was a Saturday I should not be in London. This made her feel deserted. In addition, various difficulties with her mother had already increased her anxiety and guilt. When she had an opportunity of discussing these various matters with me, of abreacting her feelings and expressing the resentment aroused by my absence, she obtained relief. Yet I had an impression that it was weeks before she could really recover from the shock.[24] Its after-effects were scarcely noticeable : an increased lability of mood, over-sensitiveness and irritability, a greater readiness to quarrel with her husband and an increased apprehension of the next raid. Apart from this last factor, all these manifestations had been her response on other occasions to experiences of a different order.

In the spring of 1941 I had a visit from the mother of a former child patient of mine, a working-class woman whom I have known for twelve years. She had been evacuated with her children, but the billets were so bad that she had had to return. She was terrified by the raids and her condition was one of acute mental suffering, though no bombs had fallen in her immediate neighbourhood. In the course of conversation it transpired that her very neurotic husband had recently been particularly difficult and that she was disappointed by his reaction to her return. More recently I saw her again. She was looking better, though her husband was as difficult as ever. At the earlier visit she attributed her reluctance to mix with other people to the raids ; this time she put it down to her domestic and financial troubles. I have little doubt, however, that it was due to her own difficulties and to the various neurotic anxieties and inhibitions from which she suffered. This case may be usefully compared with that of the mother of another of my former child patients. This woman belonged to a poorer class and seemed worn out and prematurely aged by poverty. She possessed less intelligence and was more timid than the other. When I met her in the winter of 1940 she was better dressed and looked happier than I had ever found her before. She described how the back part of her house had been hit and all the women had screamed—except herself, she added proudly. A gentleman came and was very kind and gave them tea. The family were moved to another flat, which she liked better than the old one. Her husband, who had been unemployed for many years, had now secured employment. The children were growing up, so some of her family worries had solved themselves.

When discussing the psychological reactions to the raids, it is important not to think only of the dramatic manifestations or of open anxiety. Often anxiety showed itself in a disturbance of the normal feeling of continuity and of care for the future. Some people would stop doing what was of long-range interest, e.g. working on a book. Shopping habits were a good indication. If you thought you might be killed to-morrow or lose your property, it was not worth while buying things. For some time the shops were empty. I was not aware of any particular reaction to the blitz, but at the end of September I suddenly realized that for a fortnight I had forgotten to buy flowers for my room. None of my patients had commented on this omission—which they certainly would have done under normal conditions. Attitude to pleasure is another test. Many people denied it to themselves as a propitiation of fate, often rationalizing this by saying that they could not be bothered or felt too anxious to go out. The opposite attitude of ' eat, drink and be merry, for to-morrow we die ' was not widespread.

It must also be remembered that a great number of those who did not break down or who showed no marked anxiety suffered acutely. This factor is often minimized in retrospect. Other forms of reaction were inhibition of sexual activity (or more rarely the opposite), irritability, quarrelsomeness, and anti-social activities.

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Opinions varied on the question of whether a bomb was likely to fall on a spot which had already been hit. Yet some people became so frightened if a bomb fell in their street that they immediately left the district or the town. The following unconscious mechanism may have partly determined this reaction. A profound relief that one's neighbour's house and not one's own had been destroyed was followed by feelings of guilt and fear of punish-

[24] She told me only recently that she does not think she has got over the shock really and that she feels more apprehensive of raids than before.

ment. This, again, gave rise to the apprehension: 'It will be my turn next.'

The constant droning of aircraft gave people the impression that they were immediately overhead, and many were convinced that they were being personally attacked.[24a] A patient had a feeling that the planes were God's eye watching her personally. She became particularly frightened when she heard on the wireless, while a raid was in progress, an account of a British bombing attack on Germany. The German planes were certain to hear this boast, observe her pleasure in it, and retaliate. When I asked her what the German planes stood for, she replied: 'My mother.' The Germans were spiteful, vicious, and would do what they knew would hurt you most. So you must never give away what you mind most, no matter what they did. The British Government were stupid but well-meaning. If they hurt you it would be because they did not know better. Both represented different aspects of the patient's mother. Another patient also personified the aeroplanes. He said it was reassuring to hear the anti-aircraft barrage and R.A.F. fighters overhead. It was like hearing his favourite nurse in the attic. In reply to my question what the German aeroplanes symbolized, he said: 'Mary too, and she could be quite a bully, you know.' In other cases the war symbolized fighting between parents or between parents and child.

Exhibitionistic and scopophilic impulses also played their part. A number of people went on sleeping in their houses but did not undress, so that 'if suddenly something happened' they would be dressed ready to run out. The unconscious wish to run out naked or to be rescued in seductive night attire by a gallant fireman seems pretty obvious. Mr. Walter Schmideberg tells me that in the last war many soldiers were afraid of being killed and found in a degrading situation, e.g. on a lavatory seat.

Some people attempted to deal with their fear by trying to see 'what was happening'. The strange sights that were to be seen during the bombing certainly gratified curiosity. At night, flares, searchlights, fires, etc., provided a display of fireworks. During the day, ruined buildings revealed to the curious their inmost secrets. Here two walls were gone, but a table laid with cutlery and glass stood intact. There nothing remained but a single wall with a bath suspended aloft. A patient was astonished because so many nice houses now looked so incredibly dirty, and he gleefully described a house of which only one wall was left and where, above the mantelpiece, one could see a number of pornographic pictures.

Langdon-Davies (1938; 93) quotes a Spaniard as saying: 'That night also I could not sleep. The memory of what I had seen overtaxed my senses. For some days I lived in a bad dream. That house wide open from top to bottom, leaving all its intimate family details exposed. . . . I shall always be seeing them.' (The symbolism of a body cut open seems obvious.) I once tried to describe scenes of this kind to a lady who had left London, and she simply could not bear to listen. Her conscious disapproval of sadism was very marked and she seemed to have intense unconscious conflicts in this connection.

The police were obliged to issue appeals to the public to desist from 'sightseeing', as sometimes people went in such numbers that they hampered rescue work and created traffic problems. A patient told me that when she brought her little girl aged nine to London, the child, red in the face with excitement, exclaimed: 'Look, Mummy, what a lot of lovely bombed houses!' When some time-bombs which had fallen in my district were to be exploded, people assembled an hour before the appointed time, with a look of expectation on their faces like a crowd before a football match. One child was heard to ask, 'Will they blow up the whole town, Mummy?' and was quite disappointed at the reply. Some people apologized for their enjoyment by saying that naturally they did not want anyone to get hurt. Yet a patient of mine (a borderline obsessional) proudly enumerated all of her personal acquaintances who had been killed in raids, and asked me—as if it were a question of the rules of a game—whether she was entitled to take the friends of her friends into account as well.

An Austrian refugee (schizophrenic), who came for analysis after the raids had ceased, told me that she had felt guilty for every bomb which had fallen on London. One of her main conscious preoccupations was that Vienna, where her parents and sisters lived, should be spared from bombing. In retrospect she had idealized Vienna, repressed her hostility to her family and minimized the evil the Nazis had done. Her lover, with whom she had had a long-standing relationship, left England for the United States without marrying her. As soon as he arrived there he made strenuous but unavailing efforts to secure permission for her to follow him. If he had married her, she would have been spared two years of waiting, the bombing and her mental breakdown. She had repressed her hostility against him to such an extent that for the first few months of the analysis she did not even allow herself to express any criticism of him. All her hostility was concentrated on England, where she had suffered so much and where she envied everyone who was more fortunate than herself. In her analysis an astonishing degree of hatred for the English gradually emerged. She was obsessed by ideas of having killed people she had passed in the street, usually several each day. If these ideas had had any relation to reality, she would certainly have helped to deplete the population of this country quite considerably. It was this same

[24a] *Front Line* (1942; 68) describes this reaction as being 'quite general'.

hostility which made her feel responsible for all the bombs dropped on London. Whenever the war situation deteriorated and she became frightened of a Nazi victory, she saw the events in Vienna in their true perspective and her grievances against the English receded. She used always to make demands on her father and minimize whatever he did and criticize him, very much as she behaved towards the English. But when something really serious happened, she realized how much she needed her father.

A patient who was rather frightened of the raids felt that he ought not to run away but ' face up to them.' This moral injunction covered an unconscious sadistic wish to observe disaster. As a child he had wanted to witness accidents, yet felt uncomfortable at the thought of them. His parents did not get on together. He used to wait for open quarrels to break out and ' clear the air '. These quarrels, which he both wished for and dreaded, gratified his hostility. His wish to become a doctor was partly due to the fact that that profession would present him with a legitimate excuse for watching suffering.

A hysterical patient came for treatment in the period following the raids. She said that she had been utterly wretched (for reasons unconnected with the war) and would not have cared if she or anyone else were killed in the blitz. In fact she welcomed it and derived satisfaction from the destruction wrought in London. She recalled the pleasure which it gave her to see some of her friends looking particularly glum. Another woman, who had reluctantly complied with her husband's wish that she should live in the country and had been very unhappy there, returned to London after his death in a raid. She found the raids thrilling, although she was very much frightened that she too might be killed : if it had happened to her husband, why should it not happen to her ? Yet she wanted to die and be reunited with him. One man said to me : ' The raids used to give you such a funny feeling in the stomach. Yet when there are no raids, you miss the funny feeling.'

The special conditions created by the war and success in obtaining an interesting job (her first) in August, 1939, had a favourable effect on the condition of a patient. Some months later she was given a less interesting job and had to move to London. Here the raids kept her preoccupied. But when they ceased, there was nothing to distract her attention from her personal problems, and in the summer of 1941 she came for analysis. Her usual state was one of depression. When she visited a cinema she felt quite happy, but when she came out into the street her depression would appear again in an intensified form. The raids—the fantastic reality—and the unreality of the situations depicted on the screen provided similar escapes from the drab realities of everyday life. She had a preference for cowboy and ' thriller ' films. These gratified her sadistic impulses, the excessive inhibition of which was the main reason for her fits of depression, her general inhibition and inability to tolerate reality. The raids fulfilled the same purpose. She said that she was very much frightened during a raid, but would have found it unbearable to admit her anxiety, so that she managed to screw up her courage. In spite of her fears she felt happy during the blitz. When she cycled from post to post in the performance of her duties as a warden, she felt as elated as a boy playing at being a general.

A sixty-year-old schizophrenic depressive, the wife of a former dock hand, living in what was (in the last war as well as in this) one of the ' worst districts ', came to me for analysis some months before the blitz. Among other things we discussed the air raids of the last war, which had caused her considerable distress. She had had her confinement during one, and her doctor had managed it badly because he had been in a hurry to get home. When the first daylight raids started she was frightened by them. When she was caught in a raid at my house she insisted on going to a shelter ; then she decided not to come so long as the raids lasted because her husband would be too worried about her absence. (She had one-and-a-half hours travelling each way.) For a month she lived for a cloudy day ; eventually she decided to continue analysis in spite of the raids. After a while she began to ignore them. She said she would mind them if she were well, but that she was too preoccupied with her personal problems to have time for ' normal anxieties '. Considering her diagnosis, one might have been disposed to accept her statement but for the fact that the raids had previously worried her. Also, it gradually transpired that she was not indifferent but derived positive pleasure from them. Holidays or fine weather always depressed her : she was envious of those who could enjoy them and regretted what she was missing. In bad weather or during the raids she felt better : there was less cause for envy and (since there was consequently less sadism to repress) less cause for depression. When her sadism had become more conscious, she once complained of feeling so badly that she ' couldn't even enjoy the raids '. In the period after the blitz she explained her depression by the fact that she missed the excitement of the raids. When, in 1942, there was once more an alert, she was disappointed because it was over in a few minutes, before she had time to go out into the street. During the blitz there was once a particularly bad accident in her district, over a hundred people being killed, including many children. She felt very guilty now for having ' enjoyed ' the raid. It is interesting to note that the comparatively mild raids of the last war upset her profoundly and produced a lasting effect, whilst she hardly reacted at all to the very much worse ones of this war.

This can probably be accounted for by the effect of her analysis.

Dr. Friedlander tells me that in 1939 she saw a case of paranoid dementia for a few sessions. The patient suffered, among other things, from intense anxiety and ideas of reference, and seemed on the verge of a psychotic breakdown. In 1942 he again came to see Dr. Friedlander. He had so much changed for the better that she did not recognize him at first. He told her that he had given up his job and done Civil Defence Work in the City during the blitz. He stood up to the danger well, was happy and quite astonished that anybody could be frightened. He had volunteered for the R.A.F. and felt that if, as he hoped, he could become a pilot, he would be permanently cured. He subsequently learned, however, that he had no chance of becoming a pilot, and since then his condition has deteriorated again.

I have been told that the mental balance of several pacifists and conscientious objectors who were doing Civil Defence duties seems to have definitely improved owing to the blitz. The possibility of deriving unconscious sadistic satisfaction without any sense of guilt and also of proving to themselves that they were no cowards did them good.

Elation during raids was not always due to sadistic gratification. Dr. Friedlander has also told me of a case of siren phobia which had persisted since the last war. Alternatively the patient had been worried that she might not wake up when the sirens sounded. When in June, 1940, she heard the first siren she was happy and elated the whole of the next day: she had heard the siren, it was not as bad as she had expected, and she was still alive. A man, who had been a professional officer during the last war, used to go out into the dark streets when the raids started. When he saw the searchlights and heard the gunfire and the sound of the planes he experienced a deep sense of peace of mind. It seemed to him as if the houses were moving like troops and he imagined being in his old regiment again. He felt happy because the situation reminded him of the last war, when he had been young and dashing. An Air Raid Warden admitted quite openly that he was looking forward to raids. He seemed quite a normal, well-balanced person, and enjoyed the thrill and the job he was able to do.

A patient suffering from paranoid dementia had hallucinations about people being buried and hurt. She had sadistic and sexual delusions concerning a doctor who had refused to treat her and who had said in reply to her entreaties: 'It is not a question of mercy but of practicability.' Now she saw him half-buried, suffering agonies of pain, pleading for her help, and imagined herself saying to him: 'It is not a question of mercy but of practicability.'

Non-psychotic patients rarely expressed consciously the wish that somebody should be killed. While they might have done so in peace-time they felt that things were too serious for that now. However, they often admitted that 'they wouldn't mind' if a bomb fell rather near certain persons, especially if these had been pompous and patronizing.

Naturally there was hostility against the enemy, but, on the whole, surprisingly little. It usually took the form of defiance. If a house was badly damaged, the owner would put up a defiant slogan or a Union Jack. Spitfire collections flourished in bombed districts. Even the newspapers commented upon the fact that Londoners looked happier from the day on which a barrage was put up that could be heard by everybody.[25] Though little was said about it, no doubt the one thought that sustained everybody was of the coming superiority of the Royal Air Force.

The lack of hostility shown was interesting. A patient told me that though unfortunately we have to fight, the fighting must be done with the detachment with which a surgeon conducts an operation. The ultimate overwhelming superiority of the British imposes on them an obligation to treat the Germans like rather difficult children and without feelings of revenge. A patient who had lost her husband in a raid said that the raids upon Cologne gave her no satisfaction. She had no hate against the Germans as individuals, but against those Englishmen who shirk the Army and try to have a good time. The fact that various people of this type whom she particularly disliked rejoiced at the German civilian casualties was one reason for her not getting any satisfaction from it. On one of the early mornings in September, 1940, when a large part of the inhabitants were occupied in sweeping up the broken glass in front of their premises, a little group had collected in front of a shop that had been damaged by blast. One man said aggressively: 'The only good German is a dead one', but the owner himself only smiled and continued tidying up. These examples are probably not typical, yet they are by no means isolated. During the blitz there was no hostility comparable to that manifested during the last war. This, in my opinion, is perhaps partly because people felt ashamed of their own hysterical reactions in the past, and partly because they felt some responsibility for not having succeeded in preventing the war. (I have heard such views expressed by people of all classes.) Nor was there

[25] Though a number of Langdon-Davies's (1938; 100 f.) recommendations proved sound, he was wrong in thinking that the noise of anti-aircraft fire would have such an adverse psychological effect as to make it debatable whether it should be often used. He was correct as to the frightening effect of noise in general; but 'our noise' fought 'their noise' effectively—at any rate from the psychological point of view. It is true that there were many who, especially at the beginning, mistook A.A. fire for bombs; but there were at least as many optimists who made the contrary mistake.

on the whole any increased hostility or suspicion towards foreigners and refugees, such as there had been in June, 1940. The latter was probably an indication of anxiety rather than of hatred. So long as people feel confident in the ultimate outcome, they express little open hostility.

The Government understood that morale was kept up by means both of positive and of negative transference. When a district was particularly badly bombed, the King and Queen or the Prime Minister visited it, expressed sympathy and promised revenge.

To sum up the various outlets of sadism. (*a*) Hostility against the enemy. This showed itself more in defiance than in a blood-thirsty desire for revenge. A patient who could advance no very good reason for staying in London said : ' Why should I oblige Hitler and leave ? ' (*b*) Pleasure and excitement over the destruction. (*c*) Indifference (covering callousness or sadistic pleasure) at the destruction and at people being killed. (*d*) Criticism of the Government and Local Authorities for not having made better preparations, and provided better defences, etc. (*e*) Looting, anti-social acts, querulousness and irritability. Sometimes the reaction to being bombed showed itself in a marital quarrel. Lord Woolton remarked, with some truth, that the egg-rationing produced more emotion than the whole blitz. But it may be asked how far emotions stimulated by the blitz may not have found a vent in these grievances. (*f*) A patronizing attitude or contempt towards those who left London for the ' safe areas '. (*g*) Sublimations such as activity in Civil Defence, etc.

While the blitz provided more gratification for sadistic impulses, there was a corresponding increase of libidinal ties. There was probably an inhibition of sexual activities in general (although I did not observe it in my patients),[26] as a result of anxiety and reactions of sacrifice on the one hand, and of the blitz sleeping-arrangements on the other. There was also less normal social life owing to blitz conditions and to the fact that so many people had left London. On the other hand, people took more interest in strangers and became more communicative ; there were signs of a greater readiness to self-sacrifice, a breaking-down of the usual social barriers, more feeling of contact and unity. Many enjoyed shelter life because the usual conventions were removed. Again, what some people valued about their Civil Defence Work or about voluntary war work that they were doing were the opportunities for making new contacts.

Life took on a more mediæval colouring. At dusk some of the big streets looked almost like a village street : at night they were dark and deserted. One became district and even street conscious. What happened in one's own street was of vital importance,[27] whilst other districts seemed very remote. They were, of course actually further off owing to disturbances of traffic. Neighbours became more important. Everybody needed one another's help or comfort and, since so many had left London, those who remained felt that they had more in common. Many neighbours spoke to each other for the first time in their lives, often after having made each other's acquaintance in the small hours of the morning. In the early days of the September blitz, an Air Raid Warden rang at our door and asked me, somewhat to my surprise, whether we had a picture of the Colorado beetle. It turned out that he was our neighbour and needed the picture for his ordinary professional work. The British Museum Reading Room was closed owing to a time-bomb, and our local library had been hit.

The fact of the members of a group identifying themselves with each other and their leader plays, as we know, an important part in the formation of a social group and as a means of countering anxiety. (See Freud, 1921.) Those refugees who had difficulties in identifying themselves with the English (towards whom they often had strong unconscious ambivalence) as a rule suffered from more intense anxiety. They had been deeply impressed by the apparent invincibility of the Nazis. They had been brought up in the Continental tradition, which saw in Germany the greatest military power and regarded Britain as negligible. They worshipped efficiency and organization. They exaggerated English inefficiency and misjudged English reactions. But behind these conscious factors there was a masochistic fixation to Hitler, the almighty father, and an attachment to Germany, often over-compensated for by violent accusations against them. This divided loyalty made it more difficult for them to endure the raids. (Of course the reactions here described did not apply to all refugees and varied in intensity.) Similar mechanisms were to be observed in certain ' Leftist ' intellectuals, who on the whole suffered from more anxiety than the ordinary people. Their ambivalence and distrust of the Government [28] made it impossible for them to identify themselves with it wholeheartedly and wish it success. In 1940–41 they could look neither on Churchill nor on Stalin as protecting fathers, while all their castration

[26] But the opposite reaction has also been observed.

[27] I remember in September, 1940, discussing with our greengrocer, who lives round the corner, the various time-bombs in the district. At that time we were all waiting for news as to when they would be exploded. He mentioned one which had already been exploded by the Royal Engineers, but I said that I was not much interested in it but in one nearer my house. He retorted : ' But *I* was very interested in that one ; it was at the back of my shop.'

[28] Haldane (1938 ; 234), for instance, expresses the opinion that there are people in this country who would like to use the Air Force in case of civil disturbances to bomb British towns. ' And this objection to the provision of adequate shelters is, as a matter of fact, in the back of the minds of some people who have influence in high quarters. And it is one reason, if only a minor one, why nothing has been done to give us shelters.'

dread had been stirred up by Hitler. Many of them seem to have had intense conflicts over sadism, which gave rise to exaggerated fears of death and destruction.

Nothing but praise can be given for the self-sacrifice and level headedness of the Civil Defence workers during the blitz. Yet, as soon as the raids abated, there were frequent bickerings and quarrelling—partly owing to boredom. A rescue worker told me that if it was a question of saving life men would work day and night in danger and under the most trying conditions without complaint. But they would often be reluctant when it was a question of rescuing property. (Some had justifiable grievances that they were given no time or help in salvaging their own belongings.) Obviously the seriousness of the issue made a considerable difference. In 1933, when the Nazis began to persecute the Jews, a Continental Jew told me that he would quite enjoy it if some of his acquaintances were badly treated, but that the Nazis were going a bit too far for his liking. It is also possible that just as an individual's neurotic difficulties disappear for the time being if it is a question of self-preservation, so when it is a question of the life or death of others the everyday manifestations of ambivalence are temporarily suspended. The unconscious sadistic impulses are satisfied and the libidinal impulses are set free. There was a strike in progress on Clydeside when the town was blitzed. Next day all the workers turned up spontaneously. Two of my patients used to talk during the pre-blitz period on the lines of 'Lord Haw-haw'. They depreciated the English, criticized the Government, ridiculed patriotism and extolled the Nazis. All this changed the moment the blitz started. One was the boy who later on volunteered for the R.A.F.; the other one was a man with numerous convictions for sexual offences. Like his father, he never, as a matter of principle, stood to attention when 'God Save the King' was played. Thus he expressed both submission to his father and rebelliousness towards the King. I cannot go into all the causes of his rebelliousness, which included some justifiable grievances. Owing to excessive guilt over masturbation and his sexual offences, he segregated himself from other people. He had no friends. His anti-patriotism was largely a form of segregation. During the pre-blitz period, unable to get another job, he became a Civil Defence worker. When the bombing started, he assured me that, contemptuous as he used to be of his job, he would not change it now for all the money in the world. He described how they worked while bombs were falling and added: 'Oh! it was thrilling!' When the population cheered them, he almost had tears in his eyes. He was no longer an outcast, an ex-convict, a 'menace to society', but was saving lives and atoning for all he had done. Whenever he learned that bombs had fallen in my district he came round to see whether my house had been hit and he could give a hand in digging me out. When his wife fell seriously ill he nursed her in the most self-sacrificing manner. He admitted to me that it gave him satisfaction to be able at last to pay his debt of gratitude to her. He would have liked to do the same for me, by helping to save my life. He realized now, in enjoying the danger of raids, that he had a need of a thrill, and suggested that the thrill of whether or not he would be caught had been a factor in his offences. The 'need for a thrill' was a method of dealing with his fear of death or castration; at the same time it expressed defiance of the German raiders or of the police.

Ordinary peace-time life offers insufficient gratification for self-sacrifice and masochism, except in neurotic manifestations. The fact that there is more outlet for these impulses under war conditions —that war 'brings out the best in men'—is one reason why certain neurotics improve. The appeals made to housewives to give up their aluminium pots and pans met with such enthusiasm that some people began to suspect Lord Beaverbrook of having made the appeal more for its propaganda value than for any real need of aluminium. During the raids there was ample opportunity for self-sacrifice, in helping others, risking one's life, giving generously to Spitfire and Red Cross funds, in caring less for one's property. But apart from socially valuable forms of sacrifice there were many irrational ones. Some people arranged their lives and their manner of sleeping so as to have the maximum amount of inconvenience. This sacrifice of convenience reassured their anxiety. The inhibition of sexual activity was also partly due to the same mechanism. The reactions of sacrifice were partly thank-offerings for having escaped unhurt, partly propitiations. Many people become 'good' when they are frightened.[29] A patient reacted to the Munich Crisis by becoming friendly with her sister. As soon as the danger was over, she began to quarrel with her as usual. According to statistics mentioned by Dr. Carroll,[30] the figures for delinquency dropped in the first few weeks of the war.

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When people at home wonder how it can be possible to live quite happily among the dangers of the jungle or in Nazi Germany, or when people abroad find it difficult to imagine how normal life could continue during raids, it is because they are inclined to forget that even in peace-time we are surrounded by dangers. But normally we pay little attention to dangers with which we are familiar. We laugh at the dear old lady who thinks London is such a terribly dangerous place,

[29] 'The devil was sick, the devil a monk would be;
The devil was well, the devil a monk was he.'

[30] At a Meeting of the British Psychological Society.

because you may be run over in the street, or at the hypochondriac who is worried by all the possible illnesses he may catch ; but after all they are right, for these dangers do exist. Our adaptation to ' blitz reality ' implied that we had learned to take the dangers from bombs for granted and as part of life to a surprising degree. This meant being able (*a*) to stand up to a reality fraught with more and greater dangers than those of our peace-time reality, and (*b*) to switch over from the latter to the former.

This adaptation was facilitated by the fact that it took place gradually. China, Abyssinia, Spain and Finland familiarized us with the idea that civilians can be bombed and cities destroyed. The excessive reactions on the part of some people to these events were due not only to indignation, political considerations, pity, or unconscious conflicts over sadism, but also to a growing realization that the same things might happen to ourselves one day. When the first bombs were dropped on this country in 1940, they appeared harmless in comparison with what most people had expected. The first raid warnings were scrupulously observed. If you dared to go out in the streets, you were told by indignant Air Raid Wardens that you were exposing yourself to unnecessary danger and would only be creating trouble for them if you became a casualty. After a few days this stopped. When we were having five or six alarms a day it was found impossible to observe them ; and neither the danger in the streets nor the security offered by shelters and houses was so great as to justify the trouble of taking shelter every time. After a while, when people heard a siren they simply asked ' Is it " on " or " off " ? ' and there were many who did not know the answer. Soon they ceased even to ask and only felt annoyed when they found that the Underground or some shop was closed. It was jokingly said that the postmen who had orders to take shelter understood that in the Government injunction ' Go to it ! ' ' it ' meant ' shelter '. Where there were unexploded time-bombs, the street or a number of streets were roped off. But many people found it too much trouble to go round ; so that Wardens and policemen had to be posted to prevent people from climbing under the ropes. If you could produce evidence that you were on urgent business you were allowed through ' on your own responsibility '. By the time the really serious night raids started, people were already accustomed to the daylight raids. Hence the former came as less of a shock. But, even so, there was, of course, a considerable difference between the real ' blitz ' and the comparatively harmless day attacks, and the population was faced with the new task of adapting itself to the night raids.

In the first week of the blitz people in the street looked tired and worn, partly owing to lack of sleep. Some were nicer than usual and made a point of reassuring others, while some were frightened and irritable. Talk was almost exclusively about raids and bomb damage. By the end of September those who could not bear the raids had left London, and the rest had settled down to normal life in the new conditions. For some time there was great curiosity about the various forms of bombs, and the extent and locality of the damage, but such things gradually came to be taken more and more for granted. People reacted only if there were some outstandingly bad accident, or if they themselves were personally concerned. The raiders arrived with such clockwork regularity every evening that people would merely look up at the sky with the comment ' Here they come ! ' or if they were a few minutes later, ' What's the matter, Adolf ? Short of planes ? '

The adaptation to ' raid reality ' and the modification of our standards of danger and security which it implied is an interesting phenomenon. Before the blitz really started (and in the ' safe areas ' later on) people who heard of bombing, in however distant a place, were upset, and thought : ' It might have been me ! ' But Londoners soon learned to think : ' Thank God, it wasn't me ! ' An indifference developed which in normal times would have been regarded as callousness. There was only slight exaggeration in a remark made by a friend of mine to the effect that if you heard the most ear-splitting noise and a shock like an earthquake you would merely say : ' Oh ! that's nothing ! it's only the next door house that's gone ! ' Once, when I was coming back from a week-end, I was two hours late because my train had a bomb dropped in front of it and was machine-gunned. When I apologized to the patient whose appointment I had missed, he inquired with great interest what had happened. After listening to my account for a short while, he said rather impatiently : ' Yes, but what happened actually ? I mean, what was the damage and how many people were hurt ? ' I had to admit that all that had happened had been that one of the guards had had his finger wounded ; whereupon he dismissed the subject with : ' Tant de bruit pour une omelette ! ' When this patient's flat was damaged and he had a very narrow escape, I expressed my sympathy with his hard luck. He answered very sensibly and quite unemotionally : ' You ought rather to congratulate me on my *good* luck.' Yet during the August daylight raids and also on some later occasions during the blitz proper he showed quite intense anxiety on account of himself or of other people.

A patient living in a poor suburb went to L. to do some shopping, but she regretted having gone there. ' There were no more shops left,' was her only comment, ' and I paid my fare for nothing.' While a boys' conference was being held in a small town, a raid occurred. The boys went out to help

with the rescue work and re-assembled an hour later, still grimy, in the lecture hall. The lecturer merely continued : ' As I was saying when we were interrupted . . .' Some friends of mine told me that on one of the blitz mornings their charwoman arrived half an hour late. Apologizing for her lateness, she explained that ' the house opposite had come into her flat ' and that she had had to go to hospital to have some minor injuries dressed. Another friend complained (at the end of October, 1940) that a coat she had ordered had not been sent. The shop apologized, saying that ' they had had a bomb '. She answered, impatiently : ' Oh, but that's an old story : it happened three weeks ago.' It was only then that she realized the callousness of her reply. The same detachment accounted for the surprising lack of hate. People would say admiringly : ' Wasn't that a good hit ! ' when the Germans registered a hit or a near miss on an important objective. Professional soldiers appreciate the enemy's achievements objectively, but for civilians this is an unusual attitude. It must be due largely to the effects of sport upon the mentality of the nation.

In spite of Mr. Churchill's speeches and of articles in some of the newspapers, the population as a whole refused to call the Germans ' Huns '. They referred to them as ' they ', ' Jerries ' or the like. During one of the worst aftermaths of the blitz, when traffic in the district had to make quite fantastic *détours*, a bus conductor said to a grumbling passenger, in order to explain the delay : ' There's a nasty old man in the sky who drops stones.' The process of adaptation was helped by a sense of humour, since the latter implies a certain degree of detachment.

The thought of having a revolution or of demonstrating against the Government, which some pre-war writers had expected (or hoped), did not occur to anybody. Haldane (1938 ; 286) regards it as an indication of the spirit of Barcelona that a few days after the bombardment half a million persons demonstrated in order to demand the continuation of the war. In London such an idea would have been considered an unnecessary waste of time. People did not even bother to express their determination privately. I heard only one woman declare that ' of course we must go on with the war '. The old man to whom these words were addressed smiled indulgently. I came across only two persons who, in the pre-blitz period, wanted peace for fear of raids. (In both cases, I believe, this reaction was partly due to financial worries.) Later on, they stood up to the raids reasonably well, even though the house of one of them was damaged by blast. But he persisted in taking an exceedingly gloomy view of the war situation. While the night raids were accepted as an unavoidable necessity, a patient of mine became most indignant when, during the blitz period, some bombs fell in daytime. Her indignation was not directed against anybody in particular. On the same occasion I heard a man in the street fiercely denouncing the inefficiency of the R.A.F.

One gradually ceased to pay any particular attention to bombs, unless their consequences interfered with one's own life. It was reported in the papers that, after one of the heaviest raids on Malta, the following telegram was received in London : ' Please repeat Saturday's football results. Heavy bombing interfered with our reception.' Bombs became a dangerous and unpleasant but necessary part of life, almost like the fog or traffic dangers in peace time. The office boy no longer asked to be allowed to attend his grandmother's funeral, but made up a bomb story. John Strachey (1941 ; 69) relates an amusing story about a feud between two Wardens concerning their rights over a particular bomb ; and he mentions (*ibid.* ; 27) another Warden who ' displayed proudly " his " incendiary, like a fisherman his catch.'

In August, 1940, I was in the habit of going to a bathing-pool. Though the sexes were strictly segregated, the attendant thought it her duty to appear from time to time to make sure that we had not removed our ' tops '. It was at the time of the first daylight raids, while we were having five or six a day. When there was an alarm, we were made to take cover under the bushes. But already during the second alarm the attendant came out to see whether we had not removed our ' tops '. Normality had re-appeared.

A patient who had been in the country returned to London at the end of September. She was two weeks behind other people in adaptation, and it took quite a long time for her to catch up. She herself was fully aware of the difference. When she first came back to London she used to inquire what other people did, how they felt and reacted, like someone trying to learn the habits in a foreign country. Going from London to ' safe ' or ' comparatively safe ' areas was in fact like going to a foreign country with an entirely different mentality. Things that were natural to people in those parts appeared extremely funny to Londoners, but people abroad will scarcely understand why such things should have appeared so humorous. Letters from the country announcing that ' a bomb fell six miles away from here, but we didn't feel frightened ' were, as someone said, ' enough to make a Londoner laugh '. The news that ' we had a siren, but it did not do much harm ' or the serious story of how ' a bomb fell on the village green and did a great deal of damage—in fact six window-panes were broken ' called for the exercise of much tact and self-control if the hearer was not to show his amusement. I remember watching with amazement people in a ' comparatively safe ' town hurrying, and a few actually running, for shelter when an alert was sounded in daytime, or overhearing the excited conversation in the streets because a bomb

had been dropped some distance away. Eventually, however, I realized that their reaction was more normal than ours : it is more natural to be afraid of bombs than to take no notice of them.

Before the blitz, fantastic calculations were made as to the number of bombs that could be dropped and the devastation that they would cause. Some people thought that if a bomb fell the whole district would be annihilated. We now learned that even the power of the Germans to drop bombs had its limits, that not every bomb exploded and not every hit killed people, that a yard's distance could make the difference between life and death. We acquired not only a better knowledge of the effect of bombing but new standards of danger and safety.

An acquaintance of mine in a provincial town used to be quite panicky at the thought of bombing and would reiterate : ' But how can people live in London ? ' After the town had had a raid in which some twenty or thirty people were killed, he spoke about raids very calmly. He was more impressed by the fact that some 80,000 people, including himself, had survived than by the fact that twenty or thirty people had been killed. Those who had worries as to how they themselves would stand up to raids found as a rule that they did as well as anybody else, and this was a source of profound reassurance to many. Ideals of self-control were built partly upon the pattern of physical control. Being overwhelmed by anxiety was felt to be a disgrace like soiling oneself. A patient said she knew it would be bad for her to give in to her anxiety and leave London. Another had in the past gradually overcome various fears raised by her over-anxious parents, but, though she thought that her mother's fear of death and confinement was excessive, she felt she could not prove that this was so. Her parents always warned her along the lines of ' Think what might have happened ! ' The fact that it was possible to live through the raids with their unlimited possibilities of what ' might have happened ' reassured her about the yet unknown dangers.

Those who felt that they had a right to security, and who regarded it as an insult to their narcissism that *they* should be exposed to danger, had more difficulties in re-adaptation. Their anxiety was partly an expression of indignation and protest. Only when they resigned themselves to the *lèse majesté* of frustration, danger and possible hurt that the raids entailed, could they tolerate them. Fear of masochism added to their resentment. There was unconscious anxiety that, if they put up with raids without protest, *anything* might be inflicted on them. The English have a good deal of masochism, which allows them to accept what cannot be altered, and this attitude stood them in good stead during the raids. In contrast to this, many of the refugees have an excessive fear of masochism : hence their tendency to read humiliation into every necessary adaptation—a fact that makes the latter very difficult for them. This fear of masochism (along with several other factors, such as the persecution they had experienced under Hitler and their general sense of insecurity) accounted for the extra anxiety shown by many refugees during the air-raids. (See also p. 158.) According to Ferenczi (1926), every adaptation to reality presupposes a certain amount of masochism.

Freud (1925) pointed out that the realization of painful reality is a process in three parts : ignoring is followed by denial, and only the latter makes acceptance possible. In my opinion there is yet a fourth step, interpolated between the second and third : namely, exaggeration. Exaggeration is partly a form of denial itself, partly an over-compensation for the original denial. This mechanism of exaggeration was largely responsible for the fantastic ideas of what raids and war would be like which were current before the outbreak of war.

It was interesting to observe, both in individuals and in the nation as a whole, this alternation between blissful ignorance, emotional denials, equally emotional exaggeration, and eventually quiet acceptance of war and raids. For some people, who were politically better informed, the process began as early as in 1930 or 1932, and for the majority just before the Munich Crisis. But there were few who did not react to the realization of war and raids with intense anxiety at some time or other between 1930 and 1940, either at one of the numerous crises, at the outbreak of the war, or at the actual beginning of the raids on this country. A girl of my acquaintance became panicky when Holland was invaded, because ' we were told we couldn't be bombed unless the Germans held the Dutch ports ', but the fall of France left her cold. The same inconsistency could be observed in other processes of adaptation as well. Many people put up with the increase of prices or the necessity of having to forgo much that they had been used to, without seeming to mind, until suddenly they reacted quite strongly to something that might appear unimportant to an outsider. For some reason they had attached all their emotion to that one detail : it signified for them all the difference between normal life and frustration, between safety and danger. Having got over this particular shock, they often went on putting up uncomplainingly with further deteriorations in their way of living. The modification in our standards of security involved a period of uncertainty, which was characterized by increased suggestibility. In the early days, in August, 1940, when the alert sounded, if one person began to run, everyone ran. If one person walked quietly, the others followed suit. In a shelter it was possible to reassure people or upset them with a single word. When Londoners had acquired more realistic ideas about danger and had worked out a pattern of

behaviour for themselves, they could no longer be influenced so easily.

This feeling of uncertainty was responsible also for various mild obsessional phenomena. Some people playfully, and others quite seriously, developed such ideas as : ' If I go out (if I go there or there, or do this or this, or refrain from doing that or that) there will be a raid.' [31] Sometimes the condition had a moralizing element : the raid was felt as a punishment for pleasure or for bad behaviour. When the first raids started there was a tendency to make somewhat obsessional speculations, based upon statistical calculations, as to the chances of being hit. Even rational precautions, such as going to shelter or sleeping outside London, sometimes acquired an obsessional flavour. This was indicated by the fact that many people had great difficulty in changing any arrangement once it had been made. For certain persons going to the shelters was like going to Church. They went as good children, doing what they had been told, and hoping that as a reward for their obedience they would be protected. The following case was mentioned in the newspapers. Four old ladies, sisters, went conscientiously to the shelter every night, except on Saturdays. Having done their duty, they presumably felt that they deserved a nice long sleep in bed on Sunday. On a Sunday morning they were killed. The Coroner rightly described their behaviour as strange. Many people stayed at home but did not undress. They could rarely advance any very convincing reasons for this practice. One woman told me that all the other people in the house went to the Tube. She felt very brave for not doing so, but thought that she too must do something, so at least she did not undress. Another one felt that she ought to sit up and watch for incendiaries, but, being unable to do that, at least she did not undress. It seems that, leaving aside the issue of unconscious exhibitionistic impulses, this compromise solution was a sacrifice of sleep and convenience, an ' *ut aliquid fiat* '.

Part of the population had few rational ideas about danger and safety. Some people, for instance, were more concerned about blacking out the front windows properly than those at the back. It made little difference to the German planes whether a chink of light came from the front or the back : but the Air Raid Warden was less likely to notice the latter.

We were helped both by those who were less frightened and by those who were more anxious than ourselves : we could identify ourselves with the former, and comfort or feel superior to the latter, on whom we could ' project ' the frightened part of ourselves. The fact that others had survived danger and stood up to difficult situations was a factor of tremendous importance. Payne (quoted by Glover, 1941 ; 139) explains the improvement in a previously existing air raid phobia during the Munich Crisis on the ground that phantasy is more frightening than reality. This explanation does not allow, as Glover (*ibid*) rightly comments, for the fact that the Munich Crisis was never a real external danger but an unusually realistic danger-signal. The fact that in September, 1938, the danger of war was generally realized came as a relief to those whose apprehension of the German threat had been pooh-poohed in the past. The burden of realizing the danger and of warning others no longer fell on them alone, and practical steps were taken to deal with the situation. While some people's anxiety is relieved by strengthening their denial mechanisms, i.e. by assuring them that there is no need for anxiety, others are helped when the justification of their apprehension is admitted, even if nothing can be done to diminish it. The existence of these different reactions is of great importance for sociology and psychotherapy.

The adaptation to the new reality was furthered by the fact that the latter, in spite of its dangerous and painful aspects, offered instinctual (sadistic, masochistic and libidinal) gratifications and an increase in self-esteem. The great danger was of course to the instinct of self-preservation. But this was often successfully countered by identification with other people, with particular buildings or with the nation as a whole : ' Who dies if England lives ? ' If this identification is successful, the ego is temporarily ' projected ' on to the nation or on to the loved persons, and the danger to the bodily self is felt less. In such a condition the individual will readily forget dangers which face himself and be ready to sacrifice himself for others. But such a degree of identification cannot be maintained indefinitely and normal selfishness is bound to return.

Certain melodramatic accounts may have made people abroad wonder how Londoners could go on living under such conditions. These reports, though probably correct in detail, gave a wrong impression, because they spoke only of horrors, raids and bombs. But not every district had a raid every night, not every street was hit night after night. In daytime people went on living their ordinary lives, even if occasionally against a somewhat strange background. It is an English tradition of great psychotherapeutic value to go on with everyday affairs in moments of crisis as if nothing were at stake. What impressed me more than anything during the blitz was the way in which, in September, 1940, in the midst of tragedy, devastation and talks of invasion, the annual preparations for the spring were proceeded with in the London parks. One would have a lengthy correspondence with one's laundry over a lost handkerchief, seriously conducted by both sides. It would not occur to either party that, if either the laundry or one's own house were hit, more

[31] Dr. R. A. Macdonald has stressed the connection between these reactions and masturbation rituals and phantasies.

would be lost than the handkerchief. Not sufficient credit has been given to the shops for their part in maintaining morale. They all kept open with the usual staff, even if only one or two customers were to be seen in a big store. These received, needless to say, excellent service. One store had to close for a few days, but sent out letters explaining that this was not due to the fact that a part of the premises had been hit by a high explosive, but that unfortunately the authorities had ordered them to close down owing to time-bombs in the vicinity.

This clinging to peace-time reality, the pretence of ' business as usual ', implies a denial of the fact that there are some very essential differences. It amounts to a minimizing of the danger—hence its reassuring effect. Of course, everybody knew that he might be hit, but those who carried on fearlessly believed in their heart of hearts that they would not be hurt. The words used by Queen Victoria were displayed everywhere : ' We are not interested in the possibilities of defeat. *They do not exist* . . . ' This is a naïve denial of possibilities which, unfortunately, *do* exist. Some may deny them even intellectually, most will admit them in principle as a possibility, but without adequate emotion. If they admitted them emotionally, they would be bound to be frightened. All bravery contains an element of denial, repression and isolation mechanisms.

When it was said of someone that he was not afraid of the raids, what was meant as a rule was that he got over the fright in a few minutes or hours, usually by the next morning. Some of my patients, however, claimed that they had literally not experienced any anxiety, or only on one or two occasions. One of them was the sexual offender who was so thrilled working whilst bombs fell. He had been in the Navy during the last war, and asserted that neither then nor during the raids did he ever experience anxiety, except once. A clue to the mental processes responsible is provided by what follows. When he had his ankle fractured, he refused anæsthetics because he was afraid he might show cowardice or give away his secrets when his conscious controls were relaxed under narcotics. As a child he had been timid and meek. He became ' tough ' when he joined the Navy as a young boy. As an adult he often had fights, mostly when he was afraid he might be thought ' sissy '. Another patient had occasional intense anxiety about raids before the outbreak of war, but a remarkable absence of fear during the blitz itself. Once when she was staying in the country she heard a siren faintly in her sleep and dreamt something about some ships' sirens, saying to herself : ' These are the sounds I used to hate.' She had in fact had a mild dislike of ships' sirens as a child. January and February, 1941, were free from raids and, when thinking about the coming raids of spring, she suddenly caught herself thinking : ' What an effort it will be having to brace oneself again not to mind.' This surprised her, as she had not been aware of feeling the situation a strain or of suppressing anxiety.[32]

Another woman, a borderline obsessional, went on with her life as usual. She made a point of not allowing her habits to be interfered with by the raids. Though she suffered from severe insomnia in peace-time, she slept through almost all the raids.[32a] One day she came to her analysis in quite an unhappy state. She was the only person in the house, she said, who had not been wakened by the bombs, and now they would no longer believe that she suffered from insomnia and take precautions not to disturb her. Ordinary noises were certain to wake her : she would sleep through a near-by explosion, but the barking of a dog would arouse her, largely owing to the annoyance it caused her. It was *lèse majesté* that trivial noises should be allowed to be made when *she* was asleep. She had to be very careful when her father rested, and resented less homage being paid to her. She did not mind the raids because she felt that their magnitude was in proportion to her own importance. When she walked through the deserted streets at night and bombs and shrapnel fell round her, and anti-aircraft fire lit up the darkness, she felt that all this was being done in her honour. Though unperturbed by what frightened others, on one occasion she was scared when she met a man in an empty street. Her fearlessness, which was so much in contrast to the behaviour of ordinary mortals, satisfied her ideas of grandeur and her negativistic impulses. She had made up her mind in a somewhat obsessional manner not to be disturbed by the raids, and now she reflected thankfully on the ' secondary gain ' of her fearlessness : if she had begun to have obsessional doubts over each issue that arose, over what precautions to take or not to take and over when to take them, how much this would have handicapped her ! Her main preoccupation was whether her avoidance of precautions was ' reasonable '. When she had stumbled in her childhood she had been scolded : when she had fallen ill there had been investigations whether her illness had been caused by her over-eating, by her going out without a coat or by some other fault of hers. Everything had become a matter of obedience and of being a bother to the grown-ups : the issue for her was not so much to realize dangers and discover their consequences as to make sure that she could not be blamed. Though she had many obsessional doubts, whether, for instance, to wear a coat or not, she had no such

[32] A woman told me recently that she did not relish the idea of the raids beginning again. When I reminded her that she had been through the whole blitz without being upset, she replied : ' Yes, but I'm not used to it any more ! '

[32a] This, however, was also partly an effect of the analysis, for her insomnia did not return even after the end of the blitz.

worries or anxieties when she travelled by air. Among the very numerous injunctions of her nursery life there had been none that related to travelling by air. Taking precautions in raids was being a 'good child'. The following event reassured her. In spite of the blitz, she continued to go to the same restaurant as before for dinner. One evening she accepted an invitation to dine elsewhere and came home late with some slight qualms of conscience. She then suddenly noticed that her usual restaurant had been hit, and learned that it had happened at the time when she usually dined there. Thus, she assured me triumphantly, it was proved that goodness does not pay: if she had been 'reasonable', she would have had her dinner at an early hour, not far from her home, and would have been killed!

Mr. Walter Schmideberg has told of an officer in the last war, who, after having got into trouble for cowardice, expressed the belief that his presence was enough to make enemy aeroplanes turn back and to stop their guns shooting. This belief did not prevent him from undue care for his own safety and a tendency to expose his men to unnecessary danger. There was little doubt of his pathological character. A schizophrenic patient of Mr. Schmideberg's was convinced that the German planes were heading for St. Paul's, but that she succeeded in diverting them. She also made them turn back when they tried to attack her own house.

Though fearlessness is largely based on mechanisms of denial, the latter are in themselves insufficient to bring about satisfactory reactions in the face of danger. It is necessary that the underlying anxiety shall not be too intense and that there shall be sufficient belief in one's own omnipotence and sufficient trust in one's parents or in others. This last may take the form of religious faith. It is reported of Wallenstein that he believed himself safe from bullets and under the special protection of the Virgin Mary. He regarded as a proof of this the fact that he had escaped unharmed from a dangerous fall when he was a child. The father of one of my patients was in the habit of shouting and threatening in a manner reminiscent of Hitler. All his family were frightened of him, but the little girl less than any of the others. She was secretly convinced that, whatever he might say or do, he would never hurt her seriously. She therefore did not believe that she would be killed in the raids. When she was away from London she was worried about it, with a feeling as though her presence might afford it protection: as a child she had sometimes been able to mitigate or ward off her father's wrath against others.

In the following case (also described in Glover, 1941; 143 f.) the mechanism by help of which the patient warded off his realistic fears increased his neurotic anxieties. He had come for treatment on account of an acute anxiety state and of his inability to work. After the familiar themes of castration anxiety and fear of his father and elder brother had been analysed, his condition improved sufficiently for him to take up work again. But he was still worried about his job and told me that anxiety about whether he would finish his accounts by Christmas (he is a cashier) kept him awake at night. This was somewhat surprising in the days of Dunkirk, and, as he had never even mentioned the war, I brought up the latter subject. He answered politely that he listened regularly to the wireless and read the papers. 'Invasion?' 'Oh, well, I leave that to the British Navy.' It transpired that he had no realistic fears. During the last war he had taken a great deal of interest in the Zeppelins and the bombs they dropped. On one occasion a detonation occurred very close to him, which burst the drum of one of his ears. Since then he had not gone so near when they were shooting. During the recent raids too, as I have learned from him since, he showed much interest but no trace of fear. As a child he was always convinced that his father could cope with every difficulty or danger. He exalted him in order to have his protection against realistic fears and real dangers, but, having invested him with so much power he was obliged subsequently to be afraid of him. When I pointed out this mechanism, his remaining fears and worries disappeared. In the two years that have passed since he stopped his analysis he has felt well and free from realistic and unrealistic fears.

It does not seem possible always to establish a definite correlation between realistic and unrealistic anxieties. Some neurotics are less frightened when in real danger than normal people, others are more. Some have displaced their objectively justified anxieties on to irrational fears and appear to be free from the former, while in other cases the neurotic anxieties exaggerate the realistic fears. We do not know enough yet about the mechanisms regulating the interplay between these two types of reactions. Again, absence of fear of one type of danger does not guarantee freedom from fear of others.[33] A person may be unafraid in sport and terrified in air raids and *vice versâ*. A paranoid patient seen by Mr. Schmideberg was terrified of 'being mentally or physically attacked' in the black-out but did not mind the blitz: 'the blitz agrees with me.' There is a story about a member of the Bomb Disposal Squad who fearlessly faced all risks connected

[33] Similar inconsistencies can be observed sometimes in the attitude towards physical pain and other forms of unpleasure. For instance, a patient suffering from hysterical depressions used to be terrified of her mother beating her. She is oversensitive to blame or unfriendliness, but does not mind how often she hurts herself in the course of her work as a welder. True, these hurts satisfy her sense of guilt. But she assures me that, unless they are very bad, she just does not feel them.

with his job, yet was terrified of rats. Whether such disparities are due mainly or merely to the unconscious significance of the given situation, to past experiences, certain associations or to other factors we do not know.

A pilot came for analysis because of social anxieties and a painful tendency to continuous self-criticism. He is practically free from realistic anxiety. He had fully realized, with hardly any emotion, how heavy the odds were in the Battle of Britain, and his poor chance of surviving; perhaps there was a mild feeling of apprehension before he went into battle, but once in the air he felt nothing. He was much too busy for that. Though he had many difficulties over spontaneous aggression, he had no qualms over shooting down Germans. 'It's him or me.' He was not afraid of death—'it would come so quickly that you would have no time to think'—but feared being maimed, and more still having his face disfigured. That would increase his self-consciousness to such a degree as to become unbearable. Just as he had practically no fear of physical danger when an adult, so, when he was a boy, he had borne the occasional corporal punishments at school with equanimity: as soon as the pain stopped he had forgotten the beating. But he had felt that his father's persistent nagging was intolerable, just as now he could not bear his own tendency to criticize himself. He had to scrutinize everything he did, and even if he could not find fault with his behaviour, he still felt inevitably that he was somehow in the wrong. On one occasion he made a crash landing. The plane was smashed and he broke both his legs, but his crew escaped unhurt. His only emotion about the incident was self-reproach. He had asked his crew whether they wanted to bail out, and they preferred to crash-land. He thought now he should have ordered them to bail out and also suspected himself of having been frightened to bail out. (Actually crash-landing is very much more dangerous.) The main emotion, however, was excessive guilt for having told me of the incident in a mildly boastful manner. There was no reaction either to the actual danger—he had had five minutes during which he had to decide on the crash-landing but felt no trace of apprehension—or to his broken legs, only an intellectual realization that he was very fortunate to get away alive.

I see no reason to doubt the fact that some people simply do not experience fear in situations of danger. They may or may not have irrational anxieties otherwise, but as a rule this type of person is unlikely to consult an analyst. I recently saw an eighteen-year-old boy from the East End for an interview because he had got himself into trouble for 'indecent exposure'. His father said that he did not show a trace of fear during the blitz and put out almost as many incendiaries as he himself. His mother died from shock when a bomb fell very close by. He told me that he just did not mind being caned at school, nor being sent to prison for a week on remand. He only became sullen when people tried to force him against his will, and he obviously suffered from intense feelings of guilt about sex. During the blitz we put some neighbours up for the night when their own house was blasted and the house next door to them hit. We saw them a minute or two after the bomb had exploded and there was neither at the time nor later the slightest indication of fear. In reply to my question they assured me that they had felt nothing. The woman, who was always excitable, told us in the morning that she had slept better than she had for a long time. This was due to the 'positive transference' she felt for my husband. Her restless sleep was caused by factors unconnected with the raids.

A person's conviction that nothing can happen to him is sometimes painfully shattered if something actually *does* happen to him. In that case the shock of being hurt or losing his property will be intensified by the shock of realizing his vulnerability. This implies an injury to his narcissism and ideas of omnipotence and a break-down of the mechanisms of denial. Yet some persons with a well-developed sense of omnipotence are able to maintain it even against surprisingly heavy odds. The fact that, in spite of having lost their home or having been injured, they have nevertheless survived only increases their conviction that they were born under a lucky star. Miss N. M. Williams has told me of a woman who had lost everything she had and only narrowly escaped death. This made her lose her faith in God. But when she learned subsequently that the landing containing the lavatory in which she found herself when the bomb hit the house was the only part that remained intact, she attributed her urge to go there (diarrhœa owing to fear) to God's particular protection, and regained her faith.

A sense of guilt concerning narcissism and feelings of omnipotence (frequently fostered by upbringing) is sometimes the cause of excessive anxiety. A patient who, some years before the war, had had a pathological fear of raids and war, could put forward only one explanation: 'But then I shall be killed, and I want to live.' When I pointed out that there was at least a chance that she might survive, this struck her as an entirely new idea. Originally, with the narcissism of a small child, she had been convinced that everybody might die except herself; having been made to feel guilty about this, she went to the other extreme and thought everybody might *survive* except herself. Small children are not afraid of raids—unless the adults are—because they do not fully realize the danger. It seems that the fearless adult too regresses to an early phase of ego development. In spite of all his knowledge to the contrary, he feels as if he were invulnerable. He

ignores the danger, or else somehow manages to isolate the realization of danger signals from that of danger. The normal 'protective barrier against stimuli' (Freud, 1920; 30 ff.) consists in warding off painful stimuli and postpones the full realization of danger signals so long as the sense of reality permits. Life would be impossible if we reacted continuously to all stimuli. Even the worst neurotic does not worry about *all* painful possibilities. This warding off of stimuli is achieved largely with the help of mechanisms of denial and repression and by isolating the intellectual perception or deduction from the emotional realization. A sudden break-through of these defence mechanisms comes as a shock; every realistic fear contains an element of shock. Such a break-down of the initial denial may be brought about by realistic danger signals, by witnessing the anxiety of others, by logical reasoning (our own or someone else's) which suddenly brings home to us the intensity or nearness of danger, by certain analytical interpretations, etc. Dr. Friedlander had a patient who claimed that she did not mind the blitz. On one occasion she spoke full of contempt and hostility about a person who went to the Tube to sleep. When the analyst suggested that she too might be frightened, she reacted with panic, which gradually abated during the following days. (This pattern of reaction was typical for this patient.) Thus realistic fear stimulated by serious danger implies: (*a*) reasonable apprehension based on logical considerations; (*b*) instinctive 'reaction' to sudden sensory stimuli; and (*c*) the break-down of the initial denial.

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It will be interesting after the war to compare the reaction to raids of people who lived through the blitz and of those who were in the safe areas. We must distinguish between those who had always lived in the country and those who had left a particularly vulnerable town; and between those who regularly or occasionally came up to town and those whom nothing would have induced to leave the 'safe' district for months, or even years, on end. A London woman who was evacuated to the country wrote to me in 1939: 'If I am brave enough I might come up one day.' An old lady from Plymouth accepted an invitation to come up to town for Christmas 1939 in a letter of six pages which stressed the fact that she was in God's hands and anyhow had not long to live. But when the blitz came to Plymouth she stood up to it well. In other cases too it made a considerable difference to the individual whether he went to what he believed to be a dangerous place, or whether he stood up to danger when it arose. Most of those who were frightened before the blitz grew more so, of course, when the raids started. People in the 'safe areas' only heard vague descriptions of the horrors of bombing, and as a rule danger which one has not experienced oneself seems worse. To come up to London during the daytime in foggy weather seemed to them the height of bravery. Though there were no daylight raids at that time, they were afraid there might be one on the day on which they came up. I know of some people who left a provincial town after one or two minor raids in order to spend the war in a 'safer' place. Obviously there are marked variations between the anxiety-preparedness of different people and their assessment of danger. 'Being bombed out' was a very relative term. Some felt 'bombed out' and left the town when a time-bomb was dropped some distance from their house, while their neighbours might assure you that in their district 'nothing ever happened'.

Retiring to the country seems to have increased the fear. Most sportsmen feel that it is imperative to take up sport again as soon as possible after a mishap, as otherwise they might lose their nerve. The same seems to apply to facing other dangers too. Dr. Glover has quoted a woman living near London during the blitz period as saying: 'I must come up to town soon, or else I shall become too frightened ever to do it.' Many of those who left London felt guilty. In order to justify themselves they were obliged to exaggerate the dangers from which they had escaped. This of course increased their anxiety. It seems that for some such people 'London' became almost a phobic situation. Even in peace-time there are people who cannot bear to watch an accident or see blood. Their unconscious sadism creates a fear of retaliation. In the case of blitzed London this fear had a strong basis of reality. The initial feeling of triumph at having escaped danger turned into a fear of being hit as a punishment for having felt relieved. It seems that sometimes it was an unconscious sense of guilt towards and fear of the Londoners that kept people from coming to town, rather than a fear of bombs. Stengel has described two patients who had broken down in consequence of raid experiences. Both had had very dramatic experiences in the fighting during the last war, which made them feel that they were responsible for the death of persons in their charge. They had broken down in consequence of it, but had recovered and led a fairly normal life in peace-time, till the recent bombing re-activated their conflicts. The bombs were the punishment for the murders they thought they had committed. In the one case London had been the home of the man who had been killed. Hence his supposed murderer felt more panicky in London and safer in the country.

Stengel has drawn attention to the fact that certain air-raid fears show agoraphobic and claustrophobic features. 'The town appears as a single unit which closes down round the patient.' In peace-time, too, dislikes of town can quite frequently be observed which have mildly phobic qualities. Country life symbolizes freedom and is

as a rule associated with happy childhood memories. Town is dirty, sooty, and the air is unhealthy. For one patient it symbolized a lavatory. Sometimes mild fears of traffic and of accidents and agoraphobic reactions can be traced. For instance, a patient may be afraid of going in buses or trains, but may also be afraid of buses themselves. These reactions are likely to be intensified in times of blitz. Agoraphobic reactions are rationalized as fear of panicky crowds, the fear of buses is exaggerated and displaced on to bombing aeroplanes. Claustrophobic fears usually imply not only a fear of being in a closed space from which the subject cannot escape but a fear of being exposed to some particular danger in that space. Such claustrophobic fears found justification in blitzed London. The town or house was like a trap, where one was hit by bombs which could not be escaped.

Dr. Glover has pointed out that to some people who spent part of the time in the country and part in London, these alternations corresponded to manic and depressive periods. This, however, is only an exaggeration of the peace-time reactions of people who are happy in the country for week-ends, and unhappy in town.

Those who left London or lived in the country sometimes over-compensated for their relief at being in safety by excessive admiration for the bravery of Londoners and extreme sorrow at the destruction. Others dealt with their guilt by depreciating London, by pointing out what an ugly city it was with its slums and narrow streets and that there was nothing to regret. A woman during the winter of 1940–41 expressed her concern lest Rome should be bombed. When someone mentioned London, she retorted : ' Who cares for London, anyhow ? ' Her unconscious hostility against some of her friends who stayed in London can be guessed, but her reaction was also an attempt to justify herself for having left. Yet a third reaction was indifference. I am told that in certain ' safe ' towns it was almost regarded as bad form to refer to the war or the blitz. This attempt at denial [34] is a means of ignoring the possibility of danger that might come to them too, and a defence against conflicts over sadism and guilt. To react to descriptions of bombed London with fear that one's own town might come next was of course to some degree a rational reaction. But the unconscious fear of retaliation for having escaped danger and for unconscious sadistic pleasure in the blitz also played a part.[35]

I observed strong concern in some of my patients when provincial towns were blitzed, at a time when the attacks on London receded. These reactions were largely stimulated by the newspapers, but they were also an expression of general anxiousness. They were partly an over-compensation for the relief at not being any more the sole target for the Germans. (Others expressed this relief quite openly.) Sometimes they also covered satisfaction because certain people in these previously ' safe ' towns, who had been rather patronizing in the past, were now learning what a blitz was like. One woman said—very much in the vein of the leading articles in the papers : ' London is so much bigger, it can take it better.' The big mother city symbolized the subject herself, the smaller towns her children. It was as a rule the same patients who at the beginning of the blitz felt guilty towards the East Enders—a reaction I did not observe in people outside London. It was largely stimulated by newspaper propaganda. It was certainly true that, at the beginning at least, the poor districts had been hit very much harder. Two of my poor patients did not come to see me till the end of September. When they came again, they both said, almost in the same words : ' It's funny to see so many houses still standing.'

In the first days of the blitz when the poor districts were almost exclusively bombed and there was hardly any organized relief, feeling began to rise. Then Buckingham Palace was bombed. The effect of this event was such that an acquaintance of mine jocularly remarked that it must have been done by a British pilot, for its propaganda value. I was told of a Communist bus-driver who kept on repeating : ' Well, I should never have thought *They* would do that to *Them* '—as if the bottom of his world had been knocked out.

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We are bound to get a biassed impression if we study only the respectable classes. There is a tendency to judge by oneself and take it for granted that everybody is adversely affected by the raids, by the loss or threat of loss of property, by the severance of social and professional relations, by risks of injury and death. The ' blitz life ' represented a partial break-up of peace-time society, affording gratification for anti-social tendencies, both actually and in phantasy, and advantages for those outside the pale. An otherwise most respectable patient derived special gratification from urinating in Piccadilly Circus in the pre-blitz black-out. A working-class woman told me with

[34] Indifference and callousness are often based on mechanisms of denial. I was told that in a provincial town, which was among the first to be hit, it was at first very difficult to persuade people to take in homeless persons. After the second and third raid, however, they eagerly offered hospitality. The initial selfishness was a clinging to peace-time normality. They were refusing to believe that there was danger, that they too might be affected. When once they had faced it, their eagerness to help was partly a gesture of sacrifice. They were grateful that they themselves had escaped harm.

[35] Similar reactions were to be observed in certain Europeans who had gone to the United States. Some over-compensated for their relief at being out of danger by tremendous admiration of and concern for the English. Others almost became pro-Nazi in their attempts to find fault with England, in order to justify themselves for not taking part in the war. Then again there was an exaggerated fear reaction or, alternatively, an indifference based on denial.

satisfaction that, when the water main was hit, the flood brought a mat to her house. She conscientiously put up a notice, but, as nobody claimed it, she kept the mat. A milliner lost a surprisingly high percentage of outstanding debts when her clients—all of whom belonged to the upper and middle classes—left London. No doubt many people saved money as a result of the death of their creditors. A male prostitute was on probation. On a bad blitz night half the street, including his house, was razed to the ground. His body was not found, but he was posted as missing. He had not been at home during the night but took advantage of the situation in order to disappear. Later on he was traced. Some people changed their identity by acquiring the papers of persons who were killed during the raids.

Looting must be counted among the sociologico-psychological reactions to the raids. The very heavy sentences given at a certain period indicate that it was regarded as a serious danger. Naturally people in the neighbourhood, in particular in poor districts, were tempted to help themselves to larger or smaller objects from bomb-damaged houses. They soothed their consciences by the reflection that these things would anyhow be lost to their owners, or by the feeling that amid so much destruction the little that they took was of no great importance. I was told that Civil Defence workers very frequently took things on the spur of the moment, for which they often had no use at all. Afterwards they sometimes did not know what to do with them, and tried to sell them to one another for a few pence. After the break-up of the Austro-Hungarian Monarchy in 1918, some Slovaks went looting. When someone tried to stop them, pointing out their unlawful behaviour, they retorted: 'There is no King any more, so there can be no law.' It seems that during the blitz there was a similar unconscious attitude: if the authorities cannot stop the unlawful behaviour of the bombs, then there is no law any more. Destruction on a big scale encouraged an expression of aggression on a smaller scale. Again, looting was partly an anxiety reaction. Some of the rescue-workers who kept bombed property made out that the owner gave it to them. Obviously they felt that they deserved a present for having risked their lives.

One of the features of the blitz was 'shelter life'. The primary motive for going to shelters was, of course, the wish to seek safety. But shelter life, implying a break-down of ordinary civilized habits and privacy, afforded instinctual satisfaction. Even the squalor and lack of hygiene during the first weeks, which rightly caused an outcry, gratified unconscious impulses. A number of women ceased to take an interest in their homes and spent almost all their time in the shelters. I have seen people in the Underground, even before lunch, defying the regulations, sitting quite happily knitting and gossiping, prepared for the night. There were shelters of every type: for the young and for the elderly, the respectable and the gay, the poor and the upper classes. In some respects they were a little like clubs or like cafés on the Continent, with their better opportunities for contact. A friend told me that her maids did their work during the day with curlers in their hair and cream on their faces, in order to look nice when they went to shelter at night. People who had few belongings saved rent by going to shelters. So did those who had no fixed abode or who hoped to avoid the police. More than a year after the blitz some shelters were closed. The papers reported that they had all had faithful frequenters who expressed intense regret at having to move to another shelter. The authorities believe that a certain percentage would continue to live in shelters even in peace-time, if they were given the opportunity.[36]

There was, however, a 'negative' attitude to shelters which is more likely to escape notice. H. Wilson (1942) has drawn attention to 'shelter phobia', which accounts for many cases of apparent bravery: there were people who could not stay in shelters for claustrophobic reasons. In other cases again the reaction was determined by dislike, covering fear and disgust, of the other shelterers. A patient told me that she refused to travel by Underground in the late afternoon. (She was by no means the only one to do so, as the sight of the shelterers lying on the ground, as one walked between them in order to get in and out, was no pleasant one—though there were some who found the sight interesting.) She always hated to see poor people at close quarters. Her next association was that she might tread on them, as she crossed the platform. She was also afraid that they might be rude to her for being better dressed than they were. This patient was very timid socially and afraid of people in many situations. Other patients associated to their dislike of the shelters a fear of bad air, or bad smells, or squalor, illness, bodily contact, reminiscences of seeing their parents' bedroom, etc. Others again explained their refusal to go to public shelters by the danger of the other shelterers panicking. This expressed both fear of them and of having their own fear activated. To go to such a shelter, to give up the pretence of normality, would be an admission of fear and would stimulate more anxiety.

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[36] On the whole, it was the poorer people who went to the Tubes and communal shelters. Those in the upper classes who did not want to stay in their houses made arrangements to spend the night outside London. The time and inconvenience involved in travelling corresponded more or less to what others spent in queueing up for the shelters.

Most analysts found that patients under treatment stood up well to the raids, perhaps on the whole better than analysed ex-patients. None of my patients left London. They went on with their normal lives, slept in their houses, or, in two cases, in private shelters. Two or three went out regularly in the evening. With some patients, interpretations, in particular of unconscious sadism, seem to have definitely diminished their fears ; in other cases transference and identification with the analyst had a stabilizing effect. In order to see this in its proper perspective, we must remember that during the time of the blitz most people were in greater need of emotional contact and that sometimes a short talk with a casual acquaintance could be a tremendous help. As I have said, the ' business as usual ' attitude, the pretence of peace-time normality in all walks of life, had a deeply reassuring effect. What could be more reassuring than to continue with the daily routine of analysis, with its long-term end, expressing, as it did, the analyst's conviction that both he and the patient would survive ?

I observed so few blitz transference-reactions that I can easily enumerate them. I have already mentioned the rescue-worker who used to come round to make sure that my house was still standing. Only once, after a bad blitz, did a patient ring up to make sure that I was all right. The same patient on another occasion rang up about his appointment and my maid expressed her concern because we were late in coming back from the week-end. He very sensibly reassured her, and never even mentioned the incident to me. Undue concern for the safety of the analyst seems to have been due mainly to unconscious negative transference (as in peace-time), or to have been an expression of the patient's own anxiousness or of his sensing that of the analyst. Several patients showed considerable interest as to where and how I slept—this was at the time a favourite topic of conversation all over London. Apart from the obvious unconscious content, it was a means of ascertaining the analyst's assessment of the danger and his reaction to it. Another patient rang me up, upset because on her return to London she found her district badly damaged and her house without gas, light or water. She asked me whether I would give her some water to take home. I promised to do so, but pointed out the difficulties of transport. By the time she arrived she had quieted down and had solved the water problem. During the early daylight raids I always asked patients when the alert sounded whether they wanted to go to shelter or continue with the analysis. Only one patient wished to go. I took her to the nearest public shelter, stayed till she had become acquainted with the other people there, and then went home, promising to call again in an hour or so. By that time the raid was over. On the whole analysis differed little from what it is in peace-time. In the early days of the blitz, patients used to tell me what had happened in their part of the world and compare notes with what had happened in my district. This was the usual habit at the time. I talked about raids, damage, etc., in a natural way, like anybody else, and always took their pre-occupations and worries on a realistic level to begin with, before attempting interpretations. By the end of October people stopped speaking about raids. If a patient brought the subject up then, it was because there had been a bad one in his district or because he was otherwise personally concerned, or because it had acquired a greater unconscious significance.

The reactions of patients who were no longer in analysis were perhaps not quite so good, but the figures are too small to make any reliable comparisons. I was able to follow up the raid reactions of six former patients. All of these had been well, or reasonably well, adapted and without major symptoms in peace-time. None of them developed symptoms or had a set-back as a result of the raids, but they reacted with varying degrees of anxiety. I cannot co-ordinate their raid reactions either with their clinical type or with the length of analysis they had had. The two patients who reacted best had had only 33 and 50 sessions respectively ; both were cases of anxiety hysteria. The next three, who showed ' average ' reaction, were character cases (hysterical, schizoid and borderline, with $4\frac{1}{2}$, 3 and 5 years of analysis), and the one who reacted worst had had three years and was a case of anxiety hysteria with obsessional traits.

It is interesting to compare people's fears of war and raids during the years preceding the war with their later reactions to the actual happenings. Ever since Hitler came into power I have had a number of patients who were seriously worried about the coming war. A patient who started analysis in 1933 expressed the hope, in his most optimistic moods, that he might perhaps have a few more quiet years. I have been given the date of the outbreak of war again and again. When I told my patients in the summer of 1936 that I was going to Austria and Czecho-Slovakia for my holidays, some of them looked very dubious indeed, and one, after some reflection, decided that I should be safe till the Olympic Games were over —but not afterwards. An American came to Europe every summer. In 1938 he made his trip in January, fully convinced that by the summer Europe would be at war.

The ordinary British public felt very differently. Influenced by the popular press, few of them considered the possibility of war seriously before the summer of 1938. Even apart from those who favoured the Nazis from fear of Communism, there were many who vaguely sympathized with the Germans as being nearer in outlook and character to the British than the Latin races are. The man

in the street was peace-loving and had nothing to gain from the war, which he dreaded. He fervently hoped that some good will, regret for the Versailles treaty, and some gesture of appeasement would suffice—almost on the principle of the 'homœopathic magic' of the savages, who pour out a little water when they want rain. My charwoman declared one day that 'of course a great country like Germany should be given an outlet to the sea'. Ignorance of the conditions on the Continent and of the complexities of the situation was blatant, even among fairly well-educated people. During the Munich Crisis I made an attempt to explain the issue to my Irish maid. She tried hard to follow me, and suddenly her face lit up, and, pleased at having understood the matter at last, she said: 'Czecho-Slovakia; that has something to do with the war, hasn't it, Madam?' In December, 1939, I heard a girl clerk at the Post Office say in reply to some enquiry: 'Czecho-Slovakia? . . . that's a neutral country, isn't it?'

When in 1933 the first news came about the Nazi atrocities, a patient reacted with an aggravation of his condition, saying: 'If such things can happen, then my worst nightmares may also come true.' The Nazis' rise to power was a strong contributing factor in the break-down of a Left-wing, politically active person. For another patient the war, which he regarded as inevitable, was a repetition of Biblical punishments. In several cases the main analytic material for years consisted in discussing political events. A woman worried about her children would be particularly concerned about children mutilated in raids. A man concerned about his finances would spend hours discussing America's financial policy. A patient with unconscious fear of starvation would be concerned about Britain's food in war-time. One patient used to read, at first with horror and then with open satisfaction, detailed descriptions of tortures in concentration camps. His preoccupation with these reflected his reactions to the not too severe beatings he had received in childhood. Sado-masochistic ideas found ample satisfaction in reactions to the invasion of Abyssinia, in the coming war, and in cruelties committed by various belligerents. It depended on the patient's conscious interests and unconscious complexes which aspects of the news he picked out.

People's dread of any particular aspect of the coming war was determined largely by their actual experiences during the last war, and by unconscious symbolism. For some patients the outstanding memory of the last war was bad or insufficient food, for others the depression and drabness of the atmosphere, for others the fact that their father was away, their mother was bad-tempered, and their family had moved from one set of bad lodgings to another. Sometimes fears of war were not direct replicas of bad experiences, but complicated by unconscious reactions. E.g. a little boy who had enjoyed his father's absence during the war, might, in order to atone for it, feel an urge to go to the front when he was grown up himself.[37]

War has many aspects: raids and battles are only one of them. Though some people merely had a vague, generalized apprehension of 'war' as such or feared all its possibilities, most of them dreaded most certain definite aspects, e.g. separation from their lover or deterioration of their financial position. On the whole, there was a certain consistency in fears of physical danger. Those who were most under their influence dreaded raids, invasion and that they themselves or others would be injured or killed in battle. But even so many did not react equally to all these possibilities. Nor was the fact that an individual was particularly frightened of the raids an indication as to his reactions during actual raids. Small as is the number of the cases I observed, it shows the danger of generalizations. Out of three of my patients with war phobias in peace-time, one remained panicky, one stood up to the blitz as well as the average person, and one better. Sometimes people who claimed to be fearless before the war became very frightened in actual danger, sometimes they remained as level-headed as they had said they would be, sometimes those who were frightened before the raids had no fear during the blitz. Air Raid Wardens have assured me that it was impossible to draw any definite conclusion from a person's normal peace-time behaviour as to his ability to stand up to danger.

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Various attempts have recently been made to assess the frequency of neurotic break-downs resulting from raids. This is a very thankless task. Both in peace-time and war-time, a considerable proportion of neurotics escape psychiatric observation. Some patients are in the care of general practitioners; many, especially of the poorer ones, never see a doctor. They pass for 'queer' or 'difficult', or simply suffer in silence. To many of those who were upset or bereaved through bombing it did not even occur that medical help might be desirable. Statistical observations and comparisons are bound to be fallacious when we have no reliable means of assessing the number of neurotics who escape observation in peace-time and in war-time, and the relation between the two. The facilities for psychiatric observations have altered in war-time: psychopaths in the armed forces are more likely to attract attention than they did in civilian life; ill people who had been looked after by their relations are sent to institutions if the latter are called up. On the other

[37] Sutherland (1941) observes that men whose fathers had been killed during the last war were more afraid than others of death. This may partly be due to the mechanism which I have mentioned above.

hand, evacuation of hospitals, dispersal of patients, as well as the calling-up of doctors and of patients, often make it more difficult for the latter to seek help. So long as the relative importance of such factors cannot be fully evaluated, the ostensibly more exact statistical type of observation is probably often more unreliable than 'general impressions'.

Again, we must decide what we are looking for. There were, as far as we know, few immediate cases of dramatic 'raid-shock'. It is true that a number may have escaped observation because they left for the country, or did not present the dramatic or classical symptoms that were expected. Many were quite efficiently dealt with by the rough and ready psychotherapy of the Civil Defence personnel and of general practitioners. Though the tendency to regard neurotic cases as somatic, or to treat them on moral lines, has somewhat diminished in recent years, it is still considerable enough. The observation made by Pegge (1940) that, though he was consultant psychiatrist to four hospitals, only one of them found any psychiatric air raid cases, is significant.

Some cases of acute break-down which quickly recovered were reported in the literature. But we have as yet few observations as to how lasting these recoveries were. Then again there were cases which showed no immediate reaction at all, but deteriorated later on. A patient of Dr. Friedlander, a woman of 60, was with her husband when he was killed. All through her life she had had frequent periods of depression. She did not seem to react to the raid; in fact for three months she felt better than before. Her good condition was a sort of elation at having escaped alive. Then she suddenly deteriorated when she fully realized all that she had lost. In the analysis, whenever she brought up the tragic event she felt guilty: 'I do miss him so, but I know I ought not to think of it' —it was God's will and she ought to accept it, etc.

It has been rightly stressed that most of those who broke down in consequence of the raids were psychopaths. But this does not dispense us from trying to assess in what way and degree their condition was affected by the raids. The impression of Dr. Macdonald, for instance, gained from consultations, is that a number of psychopaths seem to show more psychotic traits than they probably would have done before the war. He has in mind particularly patients who did not seem to react at all to the raids but now show a marked feeling of insecurity and withdrawal from reality. But it is difficult to assess such impressions correctly, because, apart from other difficulties, so many other factors have to be taken into account: wartime factors such as rationing, evacuation, constant stress and various anxieties, as well as different events in the patients' personal lives, whether connected with the war or not.

It is quite possible that the full psychological effect of the raids will be observed only in ten or twenty years. The very mild raids of the last war certainly often produced lasting effects, either directly, or because the parents' fear affected their children. But it is conceivable that our generation, aware for years of the danger to come, will react differently from the last one, which was brought up with illusions of Victorian security.[38]

It is instructive to compare the following two cases of anxiety hysteria. The first patient is a woman in her early thirties in a very acute state of anxiety, who came to see me several years before the war. She could not bear her husband's absence even for one night, and disliked it even in the daytime. She was terrified of war and raids. She felt that war would take away her husband and kill or injure her and her baby. 'War' symbolized her very frightening mother. The physical fears stimulated by masturbation and abortion were displaced on to wars and raids. Her break-down had been precipitated by her having had a baby and by her elder sister's break-down. These events had increased her fears of retaliation. Her husband was a protection against her mother and her sister. Hence she could not bear his absence. At a deeper level, however, he was a mother substitute, and her fears for him were determined by unconscious death and castration wishes. He was also a protection against sexual temptation. Hence she could not bear his absence at night. The analysis lasted for only 50 sessions, with satisfactory results. The patient has since had more children without any neurotic reactions, has stood up well to the war, raids, and her husband's absence, and has been keeping well for a number of years.[39]

The second patient is also a woman in her early thirties. She suffers from intense mourning for her husband, who was killed in the raids, from agoraphobic, claustrophobic and hypochondriac anxieties, depressions, air-swallowing, and an inability to work or occupy herself. She had told the consultant physician that before her husband's death she was normal. It soon transpired that this was not so. She had been a hysterical child, with numerous anxieties, always laughing or crying, very jealous, suffering from fits of temper and depressions. Her mother died suddenly, when the

[38] Apart from the individual's personal reactions and the objective conditions of the raid (its severity, etc.), various other factors determine reactions. National temperament, tradition, upbringing, emancipation of women, conditions of feeding, faith in leaders or in ultimate victory—all play a part. It does make a difference whether people have been warned to expect raids or whether they have been falsely reassured. In the latter case the injury to the national feeling of omnipotence and narcissism is bound to come as an additional shock. Again, Haldane (1938) has rightly stressed the psychological situation of the pious Spaniards who were attacked by their fellow citizens with the blessing of the Church.

[39] This case is reported at greater length in M. Schmideberg (1940).

patient was fourteen, from pneumonia. For some time she was torn by remorse, as she had on occasion openly expressed a wish that her mother should die, and as her elder sister had reproached her for her unkindness towards their mother. When the patient was eighteen her father, to whom she was deeply attached, died as the result of an accident. Her reactions to his death were very much less intense than to that of her mother. She became a nurse and did her work quite well. She had some neurotic reactions, e.g. she was over-anxious she might make a mistake in giving patients medicine, and was worried when one of them died as to whether it was not due to some fault of hers. When she had some trouble with her nails, she wondered whether it was not caused by venereal disease. But on the whole she was reasonably balanced and cheerful. She had two love-affairs, without any conscious guilt, and spent one year abroad with her lover, a married man. On her return to this country she volunteered to nurse lepers. When this offer was not accepted, she went to nurse open tuberculosis cases. She acquired tuberculosis herself. Soon afterwards she married.

The tuberculosis brought the neurosis into the open. While she had had no compunction about her relation to her lovers, she now felt exceedingly guilty about her marital life, a state of things which was partly brought on by the doctors' exhortations to be moderate in *all* respects—injunctions which repeated parental prohibitions. She now felt that her life with her lover had been an 'excess' and that tuberculosis was a consequence of it, or a punishment for it.

She developed claustrophobic, agoraphobic and hypochondriac reactions, worried lest she or her husband should die. She could not bear his absence and was reluctant to go out by herself. Her husband was loving and protecting, and the marriage to all appearances a happy one. After three years he was killed in a raid. The patient's intense reaction to his death began to subside slightly after some months. She began to go out again, but, overwhelmed by guilt over mild attempts at flirtation, reacted with a deterioration in her condition. To take an interest in any other man would mean being unfaithful to her husband. She became markedly worse exactly a year after his death. She had been told that she would feel better after a year. With an obsessional faith in dates, she had clung to this hope, and the realization that she felt just as much upset as ever shattered her. Her main preoccupation was to read religious books and to speculate upon whether there was an after-life in which she would be re-united with her husband. A few months later she came for treatment. She took no interest in clothes or food. She avoided all contact with men, neglected her appearance and in particular did not want to make up, because if she fainted when in town, as she always feared she would, people would not realize that she was ill. The sexual element in these fears is obvious. She had to come to me by Underground, and was afraid that if she had a fit of anxiety she might not get a taxi. Only the fact that for some time she did not have this fit reassured her.

The shock she had felt when she first coughed up blood repeated her reaction to her first menstruation. She felt ashamed and resentful that she had to rest after lunch, when she was ill. It reminded her of when she used to be sent to bed as a punishment. The fear of not being able to get air was determined by her wish to throttle other people. Air-swallowing and various hypochondriac worries were precipitated by her pneumothorax. The former was also a displacement from flatus, the latter were largely determined by ideas of pregnancy. So was her worry about her belly being too big. She had dozens of belts which she did not wear, cupboardsful of bottles of medicine which she did not take. The idea occurred to her that certain tablets might be poison and that the doctor might have made a mistake when prescribing them. As a nurse she had been too scrupulous about giving tablets—as an over-compensation. Feeling too guilty to spend money on enjoyable things, she spent it on doctors. Before she came for analysis she went to a different doctor every few days or weeks, but rarely heeded his advice. She had displayed the same ambivalence towards her parents, and later towards religion.

The realization of even superficial manifestations of ambivalence towards her husband invariably produced a worsening of her condition. Once she observed that her mourning had been accentuated by guilt over the fact that she had grumbled to him when she had last telephoned to him: in a similar way she had felt conscience-stricken after her mother's death. Next day she was suffering from more intense anxiety. So I considered it safer to concentrate on the infantile material, her ambivalence towards her parents, jealousy and hate towards her sisters and younger brother, guilt over sex, and the analysis of the transference-situation and present-day reactions. The analysis had lasted for three months and had progressed satisfactorily and her condition had improved, when one day she told me that she had been looking after some children. She felt worried by the question of how, if there were an air raid and one of the children were killed, she should break the news to the mother. I wondered for a moment whether I should take the safer line and interpret her hostility towards the child and the child's mother, but then decided to take a risk, and asked: 'How were you told of your husband's death?' She broke down. Eventually she told me that she had been rung up in the middle of the night and told that he was dangerously

injured, that she had had great difficulties in getting a car, that in the hospital she had not been allowed to see him, and had then been told of his death. People had been too busy with the other casualties to pay much attention to her. She had just had to control herself. Next day the patient arrived in a very acute state of anxiety. She had had an anxiety-attack in the Underground, and, as she had always feared, at first nobody had taken any notice of her, and then it was only with difficulty that she had been able to get a taxi. These factors had made her anxiety worse. I pointed out to her that being so much upset about these events expressed the delayed reaction to the shock when she had learned of her husband's injury. She then proceeded to tell me that she had never really believed that he was dead. She often believed she saw him in the street. She did not want him buried so soon; she thought he might still be alive. When she clung to the hope that she would feel better after a year, she must have thought secretly that he would return after a year if she behaved well. She had told me on one occasion that she might have a love affair, but would never marry again. As it now turned out, this was because she still had a belief that her husband was alive.[40] Speaking about these matters did not relieve her, however. She was frightened to be left alone, felt unable to leave me, and afraid of going mad. (Incidentally, her mother-in-law is in an asylum.) Eventually I asked a friend of hers to call for her and to look after her for a day or two. Next day she felt a little better, but was at first reluctant to see me, fearing that she might again get upset. She did then come, but was frightened to come alone. I did my best to smooth matters over, encouraged her to find an escort and concentrated on the analysis of infantile material and the transference situation. These interpretations too bring out reactions, but they can be kept under control. Her hostility towards her husband is coming more and more to the surface, but I have no intention of interpreting it for some time yet.

The neurosis of this patient, while her husband was alive, was similar, both in form and structure, to the first case. The husband's sudden death altered both its intensity and quality. It increased her guilt over her sadism, in particular, as well as her sense of guilt and insecurity in general. Just as he died (and her parents before), so anybody she was fond of might die. She had feared he might die, and he did: now her other fears too might come true. The death of all those she loved was like her illness, God's punishment for her wickedness. She brought disaster upon everyone. For having robbed another woman of her husband, her husband was taken from her. Now she had to be as lonely, unhappy and unattractive as her lover's wife had been. While his loss intensified her fears, against which he had been a protection, anxiety was also a defence against mourning. Sometimes when she speaks about him, she suddenly feels that his loss is unbearable, and then she will say that, bad as the anxiety is, it is nevertheless more tolerable than this feeling. Also she knows, and everybody points out to her, the absurdity of her worries. But his death is only too real a fact. It seems that she never fully abreacted what she felt when she suddenly learned of his death, and that she is still warding off the full realization of all its implications. Every step in this direction acts as a shock. Her mourning contains many elements of regret for all that she missed in the relationship, e.g. that she was sexually inhibited or that she put off having a baby. Moreover, she misses not only him but the comfort and luxury he provided. Feeling too guilty to admit that she minds not having a car, she has to work herself up into a state in order to justify taking a taxi. While he was alive she had no need to work. Now only her neurosis protects her and justifies her idleness.

* * * * *

I am indebted to Dr. George Franklin for letting me have the following notes:—

I. *General Observations.*—(1) The number of 'neurotics', i.e. cases of nervous debility, was very much less than in peace-time. (2) Amongst my practice of 7,000 patients, the number of epileptics and suicides was very much less than in normal times. (3) Women, and some few men, who reacted to the bombs immediately by turning hysterical suffered from very few, if any, after-effects. (4) The opposite applied practically exclusively to men. (5) Women were apparently more anxious than men. (6) One case of dementia præcox was obviously aggravated by the war, in another case the deterioration was less marked. (7) One case of homicidal paranoia became definitely worse after heavy raids. (8) Apparently normal people drank more alcohol. (9) The obviously neurotic appeared to improve. (10) Sexual desire, especially in women, was much intensified during the blitz. A number of men complained to me about their wives making excessive demands, and I know of very many who were unfaithful to their husbands. (11) Children were little affected by the bombs, unless their parents showed fear. (12) People who were indifferent to the raids became very anxious about

[40] She has told me since that she cannot bear to see her father-in-law, because he speaks about her husband as if he would just turn up for lunch. As she is fighting against her own inclination to believe that he is alive, she finds this attitude unbearable. She cannot visit any of the places where she used to be happy with her husband. She cannot bear to look at his photographs. She only did so once, in a raid. She was convinced that she would be killed and then be with him again. Whilst bombs fell and fires burnt, she was able to spread out all his photographs. But in a more normal state she could not stand it.

them, as soon as they had any practical experience of bombs. (13) All women in labour were absolutely indifferent to the worst raids. Even the day after the confinement they took very little notice of bombs. (14) During the raids when a large number of people were injured or frightened, I found that women became more excited and talkative, but their clinical condition was always good. On taking the pulse and examining generally the physical condition of men (in particular husbands and fathers) who had appeared calm, they often showed definite signs of shock. They usually recovered much slower than women. (15) Women who were normally classed as hysterical by the doctors usually stood up to the bombs astonishingly well; this also applies to those women when in labour; I have observed them on several occasions. (16) People who admitted they were afraid and reacted to the bombs without suppressing this fear or the impulse to run away, were little affected by the raids.

II. *A Case of Hysterical Deafness.*—A woman aged 26 years. There was no former history of functional or organic nervous disorder. She was quite unassuming and intelligent. She had never visited a doctor before. The raids did not upset her unduly, and she always prided herself on this fact, until one evening in November, 1940, a bomb struck her block of flats, and the first thing she realized was that her flat was 'falling about her ears'. She did not hear the bomb, and escaped unhurt, but noticed immediately afterwards that she had difficulty in hearing people speak—greater difficulty in the house than outside, her deafness worse at night. This worried her considerably; she consulted several specialists. All of them told her that there was no apparent cause for her deafness. She then came to me twelve months after the occurrence, was nervy, anxious and sleeping badly, and could only hear when I shouted. I discovered by accident that, if I was in the next room, I did not have to talk so loudly, in fact little more than normal speaking could be heard by her. I did not know the explanation for this. I then thought that it was a hysterical deafness and without further investigation I decided to hypnotize her. Before doing this I told her on each occasion that she would carry out my instructions when hypnotized, and much to my surprise she was able to hear the merest whisper, and, by drawing her attention to this fact and the fact that her deafness was a psychological reaction to her not having heard the bomb that hit her house, her deafness disappeared within a very short time, and as far as I know she is now quite well. I think the important facts are: (1) the pride she took in her clearness of hearing; (2) the fact that she did not hear the most important of all the bombs, i.e. the one that struck her own house. She was very much upset that she could not trust her hearing.

III. *A Case of Hysterical Paralysis.*—A man aged 36 years. All his relatives were neurotic, drunkards, etc. For many years he had suffered from 'gastric or nervous trouble'. He developed the idea that he was paralysed—first his legs; so he went to bed. At the end of six weeks he was completely paralysed, he even had to be fed and shaved. Physically he was quite fit. It was impossible to convince him that he was not paralysed. Suggestive treatment failed. Hypnotized, he told me he was anaphylactic to serum; so, without telling him, I gave him a dose of Horse Serum. He reacted to it, produced plenty of muscular movements, sufficient to impress any normal patient about his power of movement, but it produced no effect except that he could now move his arms. His original reaction was so severe that I was afraid to repeat the experiment in case it should paralyse more than his muscles. One night a big bomb was dropped behind the nursing home and severely damaged it, and everybody was badly frightened. I proceeded to see if the patients were all right, when, to my astonishment, I found the patient at the bottom of the stairs, badly frightened, but walking about. He left the home two days later completely cured, and remains so to this day.

* * * * *

SUMMARY

There were very much fewer dramatic reactions to the raids than had been expected. It is true that a number of cases of 'raid-shock' have probably escaped observation and that many of those who could not stand the raids left for the country. But the majority of the population adapted itself to the new 'blitz reality'. It did so by acquiring new standards of safety and danger and by gradually learning to take the bombing as an unpleasant but unavoidable part of life. Fearlessness was usually based on the secret conviction 'I cannot be hurt'—an emotional denial of the possibility of being hurt and regression to the narcissism of the baby. Adaptation was helped by identification with those less frightened than oneself and 'projection' of the frightened part of oneself on to more timid people. Activity, providing a sublimated outlet for aggressiveness and countering the feeling of helplessness, was a help. Rational fears were increased by irrational ones. Yet the 'blitz situation' also provided ample libidinal, sadistic and masochistic satisfaction. The condition of certain neurotics improved.

REFERENCES

BODMAN, F. (1941). 'War Conditions and the Mental Health of the Child', *Brit. med. J.*, **2**, 486.

BROWN, F. (1941). 'Civilian Psychiatric Air Raid Casualties', *Lancet*, **1**, 686.

BURBURY, W. M. (1941). 'Effects of Evacuation and Air Raids on City Children', *Brit. med. J.*, **2**, 660.

BURLINGHAM, D. and FREUD, A. (1942 a). *Young Children in Wartime* (Allen and Unwin).

—— (1942 b). *Hampstead Nursery*, XXth Report, September.

CALDER, RITCHIE (1941 a). *Carry on, London* (Secker and Warburg).

—— (1941 b). *The Lesson of London* (Secker and Warburg).

FARSON, N. (1941). *Bomber's Moon* (Gollancz).

FERENCZI, S. (1926). (*Trans.* 1926.) 'The Problem of the Acceptance of Unpleasant Ideas', *Int. J. Psycho-Anal.*, **7**, 321.

FREUD, S. (1920). (*Trans.* 1922.) *Beyond the Pleasure Principle.*

—— (1921). (*Trans.* 1922.) *Group Psychology and the Analysis of the Ego.*

—— (1925). (*Trans.* 1925). 'Negation', *Int. J. Psycho-Anal.*, **6**, 367.

FRONT LINE 1940–41: *the Official Story of the Civil Defence of Britain* (1942). (H.M. Stationery Office.)

GLOVER, E. (1933). *War, Sadism and Pacifism* (Allen and Unwin).

—— (1941). 'Notes on the Psychological Effects of War Conditions on the Civilian Population', Parts I and II, *Int. J. Psycho-Anal.*, **22**, 132.

—— (1942). Ditto, Part III, *Int. J. Psycho-Anal.*, **23**, 17.

HALDANE, J. B. S. (1938). *A.R.P.* (Gollancz).

HARRIS, A. (1941). 'Psychiatric Reactions of Civilians in Wartime', *Lancet*, **1**, 686.

LANGDON-DAVIES, J. (1938). *Air Raid* (Routledge).

LEWIS, A. (1942). 'Neurosis in England under War Conditions', *Lancet*, **2**, 182.

MIRA, E. (1939). 'Psychiatric Experiences in the Spanish Civil War', *Brit. med. J.*, **2**, 139.

PEGGE, G. (1939). 'Psychiatric Casualties in London in September 1939', *Brit. med. J.*, **2**, 764.

—— (1940). 'Psychiatric Casualties in London in September 1940', *Brit. med. J.*, **2**, 553.

RICKMAN, J. (1938). 'Panic and A.R.P.', *Lancet*, **1**, 1291.

SCHMIDEBERG, M. (1931). 'Zur Dynamik der durch die Strafe ausgelösten psychischen Vorgänge', *Z. psychoanal. Pädag.*, **5**, 310.

—— (1940). 'Anxiety States', *Psychoanal. Rev.*, **27**, 439.

SCHMIDEBERG, W. (1939). 'The Treatment of Panic in Casualty Area and Clearing Station', *Life and Letters To-day*, **23**, No.27.

STRACHEY, JOHN (1941). *Post D.* (Gollancz).

STENGEL, E. (1941). 'On a Certain Type of Air Raid Phobia', read before Brit. Psycho-Anal. Soc., Oct. 22 (unpublished).

SUTHERLAND, J. D. (1941). 'A Survey of One Hundred Cases of War Neuroses', *Brit. med. J.*, **2**, 365.

THOMAS, S. E. (1941). *Humours of A.R.P.* (Harrap).

WILSON, H. (1942). 'Mental Reactions to Air Raids', *Lancet*, **1**, 284.

ABSTRACTS

GENERAL

Lawrence S. Kubie. 'The Repetitive Core of Neurosis.' *Psychoanalytic Quarterly*, 1941, Vol. X, No. 1, pp. 23–43.

This paper is an elucidation of the phenomenon of repetitiveness as the nuclear problem of neurosis. Some of the points argued are: (1) repetitiveness is the essence of all instinctual activity; (2) all psychological phenomena are by nature repetitive; (3) all neurotic phenomena are a distortion of normal repetitiveness; (4) obsessional neurosis is a special form of neurotic distortion of the mechanism of repetitiveness wherein the drive is experienced consciously. The last point differs from Freud's concept of obsessional neurosis as specific in itself. The phenomena of repetitiveness are discussed from physiological, pathological and psychopathological viewpoints. A tentative outline of reclassification of the neuroses based on the theory of repetitiveness is offered.

Walter Briehl.

Thomas M. French. 'Some Psychoanalytic Applications of the Psychological Field Concept.' *Psychoanalytic Quarterly*, 1942, Vol. XI, No. 1, pp. 17–32.

The picture of the situation—the actual practical understanding the ego has of its integrative task—is designated as the 'psychological field'. Reviewing briefly the application of the psychological field concept to dream work in earlier studies, the author attempts to apply the concept to assumptions concerning psycho-analytic character types. He regards the idea that personality development is derived from sublimation of or reaction formation to the different erotic zones as an extremely limited view. He entertains the notion rather that it is a result of a progressive adaptive process. Abraham hinted at this idea. In considering the integrated adaptive character of normal personality development, the author raises the question whether the classical explanation of the association between personality traits and erotic zones should not be reversed. The oral, genital and anal character types are characterized as to their real significance after taking adequate account of dynamic, adaptive and organizing processes in the development of the personality.

Walter Briehl.

Carl M. Herold. 'Critical Analysis of the Elements of Psychic Function.' *Psychoanalytic Quarterly*, 1941, Vol. X, No. 4, pp. 513–544 (part 1); 1942, Vol. XI, No. 1, pp. 59–82 (part 2); No. 2, pp. 187–210 (part 3).

Starting with an analysis of the rôle of the elementary functions of objective perception and subjective sensation, this study establishes the pleasure-pain principle as the supreme psychological principle on which all libidinal reactions are

based. Thus the concept of libido represents sensual stimulation in reference to experienced or anticipated (conditioned) pleasure or pain. Libido is motivation rather than energic drive. Rejecting the concept of drive as an energy with specific aims, its energic contents are relegated to the rôle of objects of inner perception, whereas its motivating contents are recognized as sensual pleasure or pain reactions to objective perceptions or images. Further expositions of these basic views lead to the following discussions: the rôle of motility; a new interpretation of aggression and anxiety; masochism; reality test and loss of reality; the difference between dream and psychosis in reference to the missing reality test; definition of instinct in contradistinction to the rejected drive concept; the importance of hereditary qualities of the organs for perception and representation for the development of reaction types; the relations of different sense organs to the pleasure principle; etc. Sensitivity is recognized as the essential characteristic of living substance. Dulling of sensitivity as a result of many metabolic processes which are partly irreversible leads to those facts which were erroneously interpreted by Freud as manifestations of a hypothetical death 'drive'.

Author's Abstract.

Ives Hendrick. 'Instinct and the Ego during Infancy.' *Psychoanalytic Quarterly*, 1942, Vol. XI, No. 1, pp. 33–58.

This paper is a preliminary report preparing for more intensive study of the early development of partial functions eventually synthesized into the ego. The author challenges the claim of adequacy and vitality of some psycho-analytic theories concerning early infancy, for example, the assumption that the unconscious mental life of the adult (or of the post-infantile child) is a replica of the infant's experiences. The controversy regarding the development of female sexuality illustrates especially well the fallacy of seeking to define infantile life in terms of adult 'complexes'. The author proposes and elucidates the thesis that the need to learn how to do things—the 'instinct to master' (related to Freud's reference to a *Bewältigungstrieb*)—manifested in the infant's practice of its sensory, motor and intellectual means for mastering its environment, is at least as important as pleasure-seeking mechanisms during its first two years of life. Normal ego development and neurotic compulsion are considered in their relationship to the early learning period as a phase of the 'instinct to master'; compulsiveness, in its broad aspects, being considered a regression to the normal stage of the unlearned function and associated with an inability to exercise proficiently a function which gratifies the need to master.

Walter Briehl.

K. R. Eissler. 'On "The Attitude of Neurologists, Psychiatrists and Psychologists towards Psychoanalysis".' *Psychoanalytic Quarterly*, 1941, Vol. X, No. 2, pp. 297–319.

This paper is a critique of the conclusions reached and opinions expressed in Dr. Abraham Myerson's article, based on questionnaire material, which appeared in *Amer. J. Psychiat.*, **96**, 623–641. Stating that Myerson has used his data as a point of departure for a severe attack on psycho-analysis, the author elucidates numerous experimental facts to disprove the former's contentions.

Walter Briehl.

Clinical

Smith Ely Jelliffe. 'The Parkinsonian Body Posture: Some Considerations on Unconscious Hostility.' *Psychoanalytic Review*, 1940, Vol. XXVII, No. 4, pp. 467–479.

The aim is to show how to distinguish a specific element of hostility among other elements which make up the characteristic body postures of Parkinson's disease. The specific Parkinsonian posture is seen as an involuntary attitude of defence. It is assumed that all biological happenings have relation with the condition of tension. The Parkinsonian patient is menaced by both a real and a neurotic threat to his equilibrium; first, because the motor apparatus is damaged, and, second, because old instinctual conflicts are mobilized. Special attention should be paid to the character development of each patient. Undoubted cases of encephalitis completely recover. These individuals have an ability to overcome difficulties by recognition of reality rather than flight to phantasies, etc. The ego remains in a position where it can manage the damaged apparatus advantageously and restore it to adaptive functioning. Where there is a 'weak super-ego', the fact of the damage is responded to in a neurotic manner. Gutmann emphasized the tendency to paranoid forms of reaction in encephalitics frequently concealed by a mask of affability or euphoria.

A brief description of the analysis of an encephalitic with pronounced respiratory syndromes is given. The patient's condition improved markedly under analysis. Rage, sadism and defensive attitudes were marked. The actual trauma had produced a condition of helplessness which brought regressive alterations in the ego and in the function of the super-ego, and the defence conflicts of the instincts were increased.

Clara Thompson.

Charles Berg. 'Clinical Notes on the Analysis of a War Neurosis.' *British Journal of Medical Psychology*, 1942, Vol. XIX, Part 2, pp. 155–185.

This paper, which is illustrated by a detailed case history of an officer in the Regular Army Reserve of Officers, sets out to demonstrate that war neurosis is not a specific entity but rather the

precipitation of an already existing neurosis or psychosis. The necessity of resolving immediate traumatic war conflicts before the deeper causes of the illness can be understood is clearly shown. The paper is divided into five parts: (1) The war neurosis. (2) The tracing of the illness to its early foundations. (3) Illustrations of transference resistances. (4) Description of the more positive aspects of the transference. (5) A discussion on the psycho-pathology of the case. In this final section Dr. Berg discusses the conflict between the Œdipus and the inverted Œdipus situations and shows the problems arising from attempts to deal with unconscious homosexual phantasies in an environment consisting mainly of men.

R. A. Macdonald.

Margaret Mahler-Schoenberger. 'Pseudo-imbecility: Magic Cap of Invisibility.' *Psychoanalytic Quarterly*, 1942, Vol. XI, No. 2, pp. 149–164.

Pseudo-stupidity enables children as well as infantile adults to participate to an amazingly unlimited extent in the sexual life of parents and other adults. In my cases the manœuvre of the children was fully reciprocated emotionally by a parent or sibling, because it met the adult's own unconscious desire, isolated from his feelings of guilt. This utilization of stupidity is widespread because mutual sexual desires are gratified on a pre-verbal affective level, without becoming conscious through word pictures, and this renders repression or other defence measures unnecessary. Thus children and parents are able to maintain a distorted but gratifying affective communion which would otherwise be limited to mother and infant.

Author's Summary.

Else Heilpern. 'A Case of Stuttering.' *Psychoanalytic Quarterly*, 1941, Vol. X, No. 1, pp. 95–115.

The author reviews earlier papers on stuttering by Flugel, Abraham, Searl, Coriat and Fenichel. The material is gathered from a 15-month analysis of a 21-year-old man and is presented as a test of Fenichel's postulates on stuttering, namely: the erotization of speech; the pregenital, mostly anal and underlying oral character; its exhibitionistic and sadistic nature, etc. The speech disturbance of the patient dated from his fourth year and immediately followed the report of a toy torpedo. His speech function was entangled in the morbid play of his instincts according to the equation 'sharp noises = sexuality = death'. Words became libidinized as flatus and explosions. This case fits essentially into Fenichel's scheme that stuttering is a pregenital conversion neurosis presupposing an erotization of the speech function.

Walter Briehl.

Milton L. Miller and Helen V. McLean. 'The Status of the Emotions in Palpitation and Extrasystole with a Note on "Effort Syndrome".' *Psychoanalytic Quarterly*, 1941, Vol. X, No. 4, pp. 545–560.

The analyses of four patients indicated that their symptoms of palpitation and extrasystole were associated with past anxiety situations. During the course of working through their defensive attitudes in the analytic situation, the patients manifested these symptoms in connection with the development of a strong, competitive attitude towards the parent of the same sex. The origin of the symptoms clearly lay in the Œdipus situation.

Walter Briehl.

Hugh T. Carmichael. 'A Psychoanalytic Study of a Case of Eunuchoidism.' *Psychoanalytic Quarterly*, 1941, Vol. X, No. 2, pp. 243–266.

After a two year analysis of a thirty-one-year-old eunuchoid, who before and during analysis had been treated endocrinologically, the author concludes that: (1) the psychosexual development of his childhood revealed a normal Œdipus complex with no great deviation from the ordinary; (2) the weakness of his libinal drives after puberty made him unable to keep pace with other boys in sexual development and in dealing with his previous conflicts, especially with his castration fear; (3) old methods of defence against masculinity, such as passive homosexual attitudes, continued to operate after he had attained physical sexual maturity endocrinologically. These defences had to be resolved analytically before he could accept heterosexuality.

Walter Briehl.

Thomas M. French and Jacob Kasanin. 'A Psychodynamic Study of the Recovery of Two Schizophrenic Cases.' *Psychoanalytic Quarterly*, 1941, Vol. X, No. 1, pp. 1–22.

Recovered cases such as these should challenge us to understand psycho-analytically just what the process was by which the unexpected recovery took place and, secondly, to answer the question why a psychosis was a necessary step towards better adaptation to life. The material of the article elaborates two points: (1) that an acute psychosis may be a transitional episode in the process of emancipation from an old method of adjustment and 'learning' a new one, and (2) that during the acute psychosis the mechanism of recovery may be indicated in advance by the content of some of the delusions. The psychosis of the two patients—a 24-year-old woman and a 19-year-old boy—seemed to effect a better sexual adjustment to life.

Walter Briehl.

Phyllis Greenacre. 'The Predisposition to Anxiety, Part II.' *Psychoanalytic Quarterly*, 1941, Vol. X, No. 4, pp. 610–638.

The second instalment of this paper is devoted

chiefly to the practical considerations of treatment, which is discussed from four aspects, namely: the handling of the overload of anxiety; the education away from narcissism; the analysis of the 'essential neurosis'; and the management of the residual, unanalysable anxiety. Four case histories illustrate the therapeutic procedures.

Walter Briehl.

APPLIED

Géza Róheim. 'Society and the Individual.' *Psychoanalytic Quarterly*, 1940, Vol. IX, No. 4, pp. 526–545.

This article is a critique of A. Kardiner's book, *The Individual and his Society*. The author states that Kardiner's book is an attempt to base psychoanalysis on sociology. It contains so many theoretical innovations that very little is left of the original structure of psycho-analysis. A psycho-analytic ego psychology must be based on the concept of conflict between id, ego and super-ego; Kardiner eliminates this scheme and replaces it by the conflict between the individual and society. His ideas that the infant does not react to the primal scene with anxiety and that there is no Œdipus complex in the culture of the Trobriand Islanders are taken exception to by Róheim, who, in refutation, cites his own experiences, those of Malinowski and others. A further difference of opinion is expressed on the rôle of myth and folklore as well as on Kardiner's methodology.

Walter Briehl.

J. D. Rolleston. 'The Folk-lore of Venereal Disease.' *The British Journal of Venereal Diseases*, 1942, Vol. XVIII, pp. 7–19.

The author, after pointing out the almost total absence of any literature on the folk-lore of venereal diseases, goes on to discuss the many causes that have been ascribed to them and especially to the sudden appearance of syphilis in Europe, the still more numerous cures that have been recommended for syphilis and gonorrhœa and the endless variety of slang names by which they have been called.

Among the supposed causes were such things as copulating too often or copulating with a menstruating woman or an animal; interruption of copulation; retention of urine; the action of evil spirits; a dispensation of Providence to encourage chastity; and, of course, the punishment of God for fornication in general.

Among the cures were, besides every kind of animal, vegetable and mineral, from tortoises to tobacco juice, such procedures as sweating, fumigating, using magical inscriptions and smothering with pillows; the transference of the disease from the patient on to a virgin, a very black woman or a donkey; calling upon various appropriate patron saints; and finally laying the penis across the corner of a table and hitting it hard until it bled profusely.

As to nomenclature, a selection from the enormous range of slang names is given, such as 'Covent Garden Ague', 'The Crinkums', 'Ladies' Fever' and 'the marbles', besides the better-known 'clap' and 'pox'.

The author also points out how each country tended to give the name of another country to the disease. Thus the English called it the 'French Pox' and the French called it the 'Mal de Naples', while the Germans give it a Polish name, and the Poles a German one—a nice example of projection-mechanism.

A bibliography of thirty references is appended.

A. S.

William V. Silverberg. 'On the Psychological Significance of "Du" and "Sie".' *Psychoanalytic Quarterly*, 1940, Vol. IX, No. 4, pp. 509–525.

This paper is a psycho-analytical study of a philological problem—that of elucidating the mechanisms underlying the transitions that have taken place in the formal singular form of address in the German language. From mediæval until modern times this has changed according to the scheme: Du bist—Ihr seid—Er ist—Sie sind. The author suggests that this final obliqueness in the form of personal address has been a development for the purpose of protecting the 'personal nucleus' (which is threatened by manifold forces in various cultures and periods) from castration anxiety.

Walter Briehl.

BOOK REVIEWS

The Nursing Couple. By Merell P. Middlemore. (Hamish Hamilton, Medical Books, London, 1941. Pp. 195. Price, 7*s*. 6*d*.)

The title of this book indicates the special interest that held Dr. Merell Middlemore in the years immediately prior to her untimely death. No one has made a study of the relationship of a mother to her new-born infant that can be compared in its intimacy and accuracy with the work described in this book, work which was intended by the author as a foundation for a larger survey to be carried out by herself. Those of us who were her friends are sharply, almost too sharply, reminded of her by reading her book, which is in many ways characteristic of herself. Dr. Middlemore having died, the heavy task of organizing, or sponsoring, the continuation of her work is left to us.

There is much more in the book than can be crowded into the space now available for a review.

It seems to the present reviewer (who has read it many times and with increasing pleasure and profit) that the best tribute we can pay to our late colleague is to get to know her book well, re-reading it from time to time, so that, by comparing its observations and ideas with our own clinical material, we may gradually assess its true value and assimilate its findings.

The following extract will perhaps indicate the richness of the author's power of observation :

'The infants who were classed as active and satisfied within four days of birth sucked strongly at most of their early feeds. Their approach to the breast was always the same ; the tongue was guttered and stuck out, seeking the nipple. If the infant held the nipple with his lips and curved tongue, he started a chain-reflex which involved deeper muscles of the tongue and throat ; their contractions created a negative pressure in the mouth, thus drawing milk into it, and the reflex ended in swallowing. When the tongue takes up a swallowing rhythm its root acts with the throat as a kind of pharyngeal ring, while the fore-part is allied with the lips as a tactile surface which presses on the nipple and seals it into the mouth, against the hard palate. With the tongue moving rhythmically in this way, mouth and throat elements of swallowing are co-ordinated, and there is little chance of the baby developing tricks which hinder sucking.'

The main work is the classification of the behaviour of new-born infants at the breast. Dr. Middlemore watched, and from observed facts built up a classification. She then studied individual infants in order to be able to illustrate her suggested classification with clinical material. She was not trying to prove her classification to be correct or final, and she quite logically expected to modify or develop it in the course of the further work which she fully intended to do. Unfortunately, it may be a long time before anyone else will do comparable work, and so be in a position to suggest improvements.

Analysts are not straying far from their own subjects if they study this classification, for Dr. Middlemore implies that the behaviour of the first few days of life may turn up in the analytic situation, and this seems to the reviewer to be undoubtedly true.

The classification is as follows :

(A) Babies who fed steadily by the fourth day (called Satisfied).

(1) Active Sucklings.

(2) Sleepy Sucklings.

(B) Babies who did not feed steadily by the fourth day (called Unsatisfied).

(1) Excited, Ineffective Sucklings.

(2) Inert Sucklings.

(*a*) Inertia present from the first day, without evidence of irritability. These were 'sleepy babies' who failed to suck for some days ; they were called 'Simple Inert'.

(*b*) Inertia present from third to fourth day ; these were active children who became drowsy ; their inertia masked irritability ; they were called 'Irritable Inert'.

Obviously, of the two groups, the first was the more healthy, the one that comprised the infants who became satisfied in the first four days. It seems open to argument whether the active or the sleepy satisfied infants were the more normal. The unsatisfied groups comprised the infants whose emotional development could be said to be starting with a handicap.

The main part of the book is the author's clinical description of each group and sub-group. These chapters (4 to 7) must be read to be appreciated. They will be a bible for workers in this field for many a long year, and details in them will find their way into analytical literature if the book is as well read as it ought to be.

Ideas are started by study of almost every paragraph. For example, there is the following comment on aggression towards the breast :

'Another characteristic of the group active satisfied was that four of the seven bit the nipple enough to make it sore, either gripping it from time to time in the midst of hearty sucking or chewing it roughly as they moved about in fuss at the beginning of a feed. Gripping and biting were not signs of distress, for babies did not always wriggle and fuss before closing their gums on the nipple, but passed easily from sucking to biting, and back again. Nor did they bite the nipple in trying to get a better hold on it ; the two babies who bit most frequently had easy access to the breast and their mothers had suckled children before. The active babies who bit the nipple most often seemed somewhat to enjoy biting ; their biting was leisurely and quite unlike the uneasy chewing and gnawing of unsatisfied babies, and of babies who grabbed at the nipple before it slipped away from them.'

A mother who had one good and one unsatisfactory breast once described to the reviewer the aggressiveness of her infant. She said she got bitten badly, but the baby only bit the good breast, which excited him. The less satisfactory breast he just emptied and left alone. It was therefore not frustration that originated his biting.

Chapters 8 to 11 raise more general topics, and could form a basis for important discussions on the management of the newly-born and his mother. There is certainly room for much improvement in the attitude of the medical and nursing professions towards this subject.

The next piece of research which we can do is to trace the further development of actual infants whose post-natal history is known. We can also

try to correlate the phenomena of analytic transference with post-natal behaviour. It is, however, extremely rarely that a person who is old enough to be in analysis is in possession of certain knowledge as to his behaviour immediately after birth. Even in the case of children undergoing analysis the history given by the mother is by no means to be relied on in the majority of cases.

In order to find something to criticize about the book, it is necessary first to make a supposition. I would suppose that it is implied in the book that when we observe the behaviour of infants we 'get behind phantasy', that is to say, we see behaviour with no phantasy parallel. This may seem a far-fetched idea, but it happens that the reviewer has actually heard the following comment made: 'Well, at any rate, these characteristics of various infants and infant-types described by Dr. Middlemore can be considered apart from phantasy, because infants at birth cannot be presumed to have a phantasy parallel to their physical actions and reactions. In the case of older children and adults, every physical experience has phantasy belonging to it, but such a complication does not arise in the case of the new-born infant.'

If this implication is contained in the book, it must be said that it may very well turn out to be a false one. It may be difficult for some to believe that new-born infants have phantasy and unconscious emotional conflict, yet that is no argument that these do not exist. For instance, if a type of behaviour in the analytic transference can be traced back to the patient's relation to his mother which was established in the first day or two of life, it by no means follows that such behaviour is unanalysable. The reviewer is satisfied from his own work that, for instance, there is no sharp line to be drawn between a feeding inhibition that appears in the first days or hours of a child's life and one that appears, as it commonly does, as a reaction to weaning, or to the introduction of solids, or as a reaction to the first meals *à trois*.

We can claim to know what phantasy we should find in the analysis of the later established inhibitions, and the same phantasy is likely to be found in the analysis of an inhibition of feeding that starts immediately after birth. The fact is that we do not know enough to be able to put into words the state of mind of the new-born infant in a way which links his behaviour with that of an older child, and which at the same time takes into account whatever psychological limitations belong to this tender age. There is no reason to doubt, however, that something corresponding to phantasy exists in the new-born, and that this may be as important in relation to physical reality as it is in older children and adults.

What I have introduced here as a supposition may or may not really be implied in the book. The reader must judge for himself. Indirect reference to the problem can be found on pages 58 and 59, and in Appendix III.

Almost the whole of the first edition was destroyed in the London fire raid, but fortunately a second edition has been printed, so that the book is now available.

D. W. Winnicott.

El Psicoanalisis. By A. Garma. (Monografias de 'Index de Neurologia y Psiquiatria', Buenos Aires, 1942. Pp. 115.)

Dr. Garma has written a very useful text-book for his fellow-countrymen. Though confined to the space of some 100 pages, he has succeeded with excellent judgement in selecting and presenting the major issues in the different fields of psychoanalysis. The book is divided into three parts: (1) Psycho-Analytical Theory. This deals with the mental constitution (id, super-ego and ego), libidinal types and anxiety. (2) Aspects of Psycho-Analysis. These include discussions of infancy, sexual development, puberty, neurosis and psychosis, treatment, and the relation of mental to somatic disorders. (3) The Psycho-Analytical Movement. This is essentially a description of Freud's personality together with an account of the development of his work. There is a well-chosen bibliography.

E. J.

The Impulse to Dominate. By D. W. Harding. (George Allen and Unwin, London, 1942. Pp. 256. Price, 7*s.* 6*d.*)

This is on the whole a disappointing book. The first third of it, describing with much caustic shrewdness the relationship of our social institutions to war, gives an impression of penetration and raises expectations that when the author comes to his subject proper he will have something illuminating to say about it. Such hopes are not borne out by the rest of the book, for the author proffers no serious investigation of the impulse to dominate which is his avowed theme. And the reason for this is plain. The author is concerned essentially with the sociological aspects of psychology and shows little interest in any psychological or biological analysis of the sources of impulses. His attitude to psycho-analysis is polite, but characteristically off-hand. He refers to the psycho-analytical findings of the unconscious factors in relation to war as the 'neurotic' factors, thus revealing the popular view that the unconscious mind is a sporadic, neurotic and abnormal phenomenon which a 'normal' outlook need take little into account.

The rest of the book rather degenerates into a plea that the impulse to dominate need not be. The author tends to regard it as mainly an artificial social phenomenon fostered by particular types of culture, here coming close, though on a broader front, to Perry's well-known view. Atti-

tudes towards domination and submission have unfortunately been extensively 'institutionalized'. He traces in a purely descriptive fashion this tendency throughout social life and trenchantly points out that 'what the politicians and jurists are content to call peace might be better described as aim-inhibited war.' He is much taken with Anderson's conception of 'social integration'. By this is meant a social relationship of equality throughout, in which any failure to effect agreement or a beneficial interchange of ideas leads to mutual withdrawal instead of the customary endeavour to persuade, insist or compel. Such people, in effect, agree to renounce any tendencies towards either domination or submission. One might characterize this conception as that of a politician or prophet rather than of a man of science.

Among the many striking passages scattered throughout the book may be quoted the final one: 'To achieve security in adult social life we must eradicate the effects of insecurity in family life; for social relationships within the family provide the paradigm for every adult social relationship, including war.'

E. J.

Psychiatry in Medical Education. By F. G. Ebaugh and C. A. Rymer. (The Commonwealth Fund, New York, 1942.)

The appearance of a 600-page book, largely devoted to a factual presentation of psychiatry in medical education in the United States and Canada, is in itself a symbol of progress. Only a half-century ago the facts would hardly have taken more space than a 10- or 15-page article in a current periodical. The authors of the compilation have done their work carefully, according to plan, and the book should be catalogued as a worthy contribution to psychiatric research.

The book is divided into four parts. Particular credit is given to Adolf Meyer for his part in fostering the teaching of psychiatry. While it is true that Meyer was a great stimulus, it is also true that without Freud psychiatry would not be as rich to-day as it is. The authors have summarized the tenets of Meyer very clearly. It would have rounded out the discussion had they included the principles of Freud, for the authors write (p. 194) that 'we believe that the presentation of psychopathology based on the genetic-dynamic principles of psychobiology and supplemented by psychoanalytic concepts where they add to the development of this viewpoint is the most desirable approach.' They add: 'It is difficult to see how psychopathology can be taught without these psychoanalytic concepts.'

The second section, comprising six chapters, is an excellent inventory of psychiatric curriculums in the pre-clinical and clinical years.

The third section familiarizes the reader with psychiatric training for specialty practice. It would undoubtedly help the physician much to read this section, while he is considering where he should go and what methods he should be taught, in order to get the best training for his chosen specialty.

The fourth section constitutes a summary of future needs and developments. This is well done.

The book is an excellent contribution and a timely one, well written and comprehensive. It comes at a time when re-orientation is needed.

L. E. Hinsie.

War in the Mind: the Case Book of a Medical Psychologist. By Charles Berg. (The Macaulay Press, London, 1941. Pp. 272. Price, 8*s.* 6*d.*)

Dr. Berg attempts in this book a popular description for the lay public of the psycho-analytic method and even theory. He does so by presenting a series of upwards of 20 cases, largely in the form of what seemingly purport to be verbatim records. These run so smoothly, however, that one suspects that Dr. Berg's literary art has played a considerable part. The impression conveyed is undoubtedly that psycho-analysis is a much easier, shorter, and therapeutically more uniformly successful form of treatment than the common experience would suggest. This is no doubt in conformity with the aim of the book, to popularize psycho-analysis, but naturally it detracts from its scientific value.

At the same time, Dr. Berg contrives to cover a surprising amount of the analytic ground, and without any gross misrepresentation. There is a heavy emphasis on the essential part played by sexual factors, in the narrower sense of the term for the most part. There is no adverse criticism of Freud, such as one expects from a psychotherapist who is not a member of any Psycho-analytical Society. On the other hand, there is no reference to more recent theoretical developments, and the point of view, for the most part, is that of rather early Freud. Dr. Berg is surely mistaken in quoting Freud as maintaining that neurasthenia is due to *early* masturbation. His description of the formation of the ego and super-ego, also, is original rather than faithful to Freud's ideas; for instance, he states (p. 254): 'The newly developing Ego of the infant, in attempting to adjust itself to this specific environment, finds itself occupied chiefly in opposing Id wishes, or at least in grossly modifying them.' In later life this 'primitive Ego' simply undergoes a change of name to 'Super-ego'.

The printer seems to have had some difficulty with the word 'epinosic', which appears variously as 'episodic' (p. 23), and 'episoic' (pp. 258, 259).

W. H. Gillespie.

Conceptual Thinking in Schizophrenia. By Eugenia Hanfmann and Jacob Kasanin. (Nervous and Mental Disease Monographs, New York, 1942. Pp. viii + 115. Price $2.50.)

This book presents the results of a careful and well-controlled piece of research into the problem of schizophrenic thought disorder. It is based on the work of Vigotsky, and the test material consists of the 'concept formation test' originated by Ach. This is an ingenious sorting test; in performing it the subject betrays the level of his thought processes, whether concrete or conceptual. Vigotsky considers the loss of conceptual thinking to be the basic disturbance in schizophrenia (though he is careful in his paper to deny any ætiological significance to it); but he does not present conclusive experimental evidence.

The present research is based on the application of the concept formation test to (*a*) 62 schizophrenics of varying clinical types and educational attainment, (*b*) 50 college graduate controls, (*c*) 45 state hospital attendant controls, (*d*) 24 patients with organic brain disease. The authors have worked out a detailed and consistent technique and method of scoring (though the latter, as in so many psychological tests, is very arbitrary); and they find that it is necessary to distinguish not less than three grades of thinking, as opposed to Vigotsky's simple division into conceptual and concrete ('complex') thinking. They find, in fact, that thinking in true abstract concepts is practically confined to the college-trained subjects; other normal subjects generally reach only the intermediate grade of partially conceptual thinking. It is therefore essential to make allowance for a person's educational level; thus, the college-trained schizophrenics do on the average about as well as the attendant controls, but much less well than the college controls. The non-college schizophrenics also perform on a lower level than the corresponding control group.

There is also a wide variation among schizophrenics of the same educational level, and further investigation led to the discovery that this variation is related to the different clinical forms of the disorder. Thus, unimpaired thinking is found chiefly in patients characterized by many neurotic and hypochondriacal symptoms. Defective conceptual thinking is associated especially with (1) incoherence and irrelevance, (2) marked dissociation with extensive phantastic elaboration, (3) paranoid-hebephrenic types with dull affectivity. Acute episodic and paranoid types are found to be intermediate.

Thus, the results are not nearly so clear-cut as Vigotsky suggested, and they appear to rule out the possibility that this particular kind of thought disorder (which can reasonably be regarded as regressive, for a similar disability is found in children before puberty) is the essential change underlying all cases clinically diagnosed as schizophrenia. This result is scarcely surprising in view of the growing modern opinion that 'schizophrenia' is not a nosological entity. Researches such as the present should help to break it into its component parts, an important step towards a more satisfactory approach to the problem of schizophrenia.

W. H. Gillespie.

Schizophrenia in Childhood. By Charles M. Bradley. (The Macmillan Company, New York, 1941.)

The author of this small volume offers a comprehensive survey. We note that childhood schizophrenia is an extremely rare illness and that children do not show the clinical types of the adult, and are grouped differently: e.g. an 'acute' type, characterized by sudden, acute onset, with remissions and exacerbations, and a 'chronic' type, with a slow, insidious onset and development. The book has the virtue of covering the literature, and the defect of unimaginative, text-book sifting of the material. The author is attentive to psycho-biology and developmental psychology, and makes a polite bow to psychoanalysis. Of the interplay of family relationships in his patients, of their personality strivings, of the impact of their illness on the structure of their personalities, of their world-picture, of their very existence as human beings—of all this, which is the fascination of schizophrenia, the author has exactly nothing to say.

Jules V. Coleman.

A Long-Term Study of the Experimental Neurosis in the Sheep and Dog. By O. D. Anderson and Richard Parmenter. (Psychosomatic Medicine Monographs, Vol. 2, Nos. 3 and 4.) (National Research Council, Washington, 1941. Pp. viii + 150. Price, $3.50.)

Since the theme of this work borders at least on the sphere of psycho-analysis, it is interesting to observe what light behaviouristic analysis throws upon phenomena which bear a certain relation to those familiar to the psycho-analyst. It stands to reason that the method differs fundamentally from psycho-analysis. The authors have focussed their studies upon those aspects of behaviour which can be examined by physiological instrumentation—'without dependence upon psychological interpretation'.

The nervous disturbance studied by the authors (and their predecessors) made its appearance in the course of work undertaken to determine the differentiating ability of the experimental sheep under various conditions. Using the conditioned reflex method, they attempted to force the animals to distinguish, for example, between a rapidly beating metronome and a slowly beating one. It was observed that, when the problem became too difficult for the animal to solve (that

is, when the different rhythms of the metronome resembled one another too closely), the sheep was not only unable to effect a perfect differentiation, but its general behaviour underwent a change as well.

The conditioned motor reflex, elicited chiefly by the sound of a metronome or an electric buzzer, was reinforced by the application of a mild electric shock to a forelimb. The overt motor response to the signal or shock consisted of a defensive flexion movement or movements of this reaction leg, accompanied by movements of the head or trunk.

Thus, when the experimental animals are called upon to distinguish between one conditional signal and another, the first being reinforced by a shock to the foreleg but the second *not* followed by a shock, the neurotic behaviour which may be induced by such a procedure is as follows. 'Frequently hyper-excitability is manifested in both dog and sheep by restlessness, vocalization, micturition, vigorous and wild reactions of defence and offence, and a long enduring, perhaps permanent disturbance of respiration and heightening of the pulse rate. Or, on the other hand, the condition is sometimes manifested by either species by a state of deep inhibition, that is, by mildness and docility, passive stubbornness, weakening or complete disappearance of many defensive and offensive reactions, and markedly variable respiration and pulse; or there appears in some cases a gradual shift from one extreme into the other in the same animal over a period of time. The abnormal manifestations, once they have appeared, are apparently of long duration in both sheep and dog.'

In certain experimentally neurotic sheep there appeared a transfer or shifting of the habitual motor reaction pattern from one part of the body to another. The conditioned motor reflex and the spontaneous activity during the experiment involved, in the majority of neurotic sheep, defensive flexion movements principally of the reaction leg to which the shock was delivered. In one case, the reactions shifted spontaneously from the left to the right foreleg. In another, they shifted from the left foreleg to the head and neck.

'For the past 8 or 10 years observations of the behaviour of the disturbed animals when they were with their fellows in the animal quarters . . . have shown conclusively that the signs of the experimental neurosis are by no means confined exclusively to the laboratory chamber. The animals were found "to take their neurosis home with them".' All the nervous dogs were excessively shy; and the neurotic animal is apparently a frequent sufferer from 'insomnia'.[1] 'When the objectively observed behaviour of the neurotic sheep and dog is interpreted in psychological terms, it is undoubted that these animals experience apprehension and terror. Unlike the patient being examined by the psychiatrist, however, the animals cannot tell us that they are "afraid".'

The authors advance a working hypothesis to explain the effects observed. 'Repeated and prolonged emotions, incident to the experimental procedure, produce a chronic imbalance of the internal secretions, which induce a constant state of imbalance of the chemistry of the nerve cells. A change in the irritability of the nervous system results. The nervous system may become hyper-irritable. Further and prolonged stimulation of the emotions reinforces and perpetuates the changes in internal chemistry and the vicious circle of events is complete.'

We may conclude this review with a quotation from Liddell (1939) with which the authors identify themselves. 'If we begin watching animal and human situations we involve ourselves in insoluble problems. We therefore choose to attempt to standardize a neurosis-producing situation and then to explore in detail the psychosomatic consequences of the condition. We have no desire to identify the experimental neurosis in sheep with any form of human mental disorder. However, its origin suggests similarity to the human situation, where difficulties arise under social pressure.'

Walter Hollitscher.

PUBLICATIONS RECEIVED

[*Appearance in this list does not preclude subsequent notice.*]

A. BOOKS

A History of Medical Psychology. By Gregory Zilboorg, in collaboration with George W. Henry. (New York: W. W. Norton & Co. Inc.; London: George Allen & Unwin Ltd. 1942. Pp. 606. Price, $5.00 or 28*s.*)

Conscience and Society. By Ranyard West. (London: Methuen & Co. Ltd. 1942. Pp. 260. Price, 15*s.*)

Dynamics in Psychology. By Wolfgang Koehler. (London: Faber & Faber Ltd. 1942. Pp. 120. Price, 8*s.* 6*d.*)

Foundations for a Science of Personality. By Andras Angyal. (New York: The Commonwealth Fund. Pp. 398. Price, $2.25.)

From Thirty Years with Freud. By Theodor

[1] Copulatory behaviour in the female was normal in all cases. Nor was there any neglect of their lambs on the part of the neurotic ewes.

Reik. (London: The Hogarth Press and The Institute of Psycho-Analysis. 1942. Pp. 214. Price, 12*s.* 6*d.*)

Language in Action. By S. I. Hayakawa. (New York: Harcourt, Brace & Co. Pp. 345. Price, $2.00.)

Our Age of Unreason. By Franz Alexander. (New York: J. P. Lippincott Co. 1942. Pp. 371. Price, $3.00.)

Self-Analysis. By Karen Horney. (New York: W. W. Norton & Co.; London: George Allen & Unwin Ltd. 1942. Pp. 309. Price, $3.00 .

Stone Men of Malekula. By John Layard. (London: Chatto & Windus. 1942. Pp. xxiii + 816. Price, 50*s.*)

The Eclipse of a Mind. By Alonzo Graves. (New York: The Medical Journal Press. Pp. 722. Price, $5.00.)

The Human Hand. By Charlotte Wolff. (London: Methuen & Co. Ltd. 1942. Pp. xii + 148. Price, 16*s.*)

The Sexual Cycle in Women. By Therese Benedek and Boris B. Rubenstein. (Psychosomatic Medicine Monographs, Vol. 3, Nos. 1 and 2.) (Washington: National Research Council. 1942. Pp. x + 307. Price, $3.50.)

Unconsciousness. By James G. Miller. (New York: John Wiley & Sons Inc. Pp. 329. Price, $3.00.)

B. PERIODICALS

Archives de Psychologie (Geneva).
Archives of Neurology and Psychiatry (Chicago).
British Medical Journal (London).
Bulletin of the Menninger Clinic (Topeka).
Journal of Criminal Psychopathology (New York).
Man (London).
Medical Press and Circular (London).
Medical Record (New York).
Mental Hygiene (New York).
Psychological Abstracts (Lancaster, Pa.).
Psychosomatic Medicine (Baltimore).
Revista de la Asociacion Medica de Cuenca (Cuenca, Ecuador).
Revista de Neuro-Psiquiatria (Lima).
The Australasian Journal of Psychology and Philosophy (Sydney).
The British Journal of Medical Psychology (London).
The Journal of the American Medical Association (Chicago).
The Psychoanalytic Quarterly (New York).
The Psychoanalytic Review (New York).

BULLETIN OF THE INTERNATIONAL PSYCHO-ANALYTICAL ASSOCIATION

EDITED BY
EDWARD GLOVER, GENERAL SECRETARY

I. *CLINICAL ESSAY PRIZE*

Members and Associate Members of the International Psycho-Analytical Association are reminded that competitors for the Clinical Essay Prize must send in their work to the Hon. Secretary of the Institute of Psycho-Analysis, 96 Gloucester Place, London, W.1, by March 31, 1943.

The conditions governing the competition are the following.

A prize not exceeding £20 is offered.

Requirements for the Essay

The essay shall consist of a clinical record of a case investigated by psycho-analytical methods. It should clearly illustrate the events and changes in the mental life of the patient and their relation to external environment. In awarding the prize, the Judges will pay attention to acuity of observation and the clearness with which the facts are stated. If the writer wishes to draw theoretical conclusions, he must bear in mind the necessity of making the evidence for such conclusions carry conviction. It is recommended that the length of the essay should not exceed twenty thousand words.

Date of Sending in Essays; Language; Format, etc.

Essays must be submitted on or before the thirty-first day of March in any year, in the English language. They must be typescript on quarto paper with ample left-hand margin. They must be in triplicate and be sent to the Hon. Secretary of the Institute. All copies of essays submitted become *ipso facto* the property of the Institute (or its successor) while it has the appointment of the Trustees.

No Award

If no essay is submitted of merit worthy of a prize in any year, no award shall be made for the year.

Joint Award

In the event of the Judges regarding the essays of two or more competitors of equal merit, they may divide the prize-money available for distribution as aforesaid into equal parts and award it to such competitors jointly.

Eligibility

Any person of either sex, who is not a member or a past-member of the Board of the Institute, shall be eligible for the competition.

TENURE

The prize shall be given to the writer of the best essay in the opinion of the Judges submitted in any year, but the prize may be awarded to the same person twice, provided that he submits a second essay of sufficient merit in a later competition, and that the prize shall not be awarded more than twice to the same person.

TITLE

The competitor to whom the prize is awarded in any year may be called the Clinical Prizeman for that year.

COPYRIGHT

The copyright of any essay to which a prize is awarded shall become the property of the Institute. Should the author wish to quote it in whole or in part, the Institute shall not unreasonably withhold its consent. The Institute shall not publish such essay in whole or in part in English or in translation in England or abroad without the author's written consent during his life-time. Other persons who may wish to quote extracts from any prize essay shall obtain the written consent of the Institute or its successor, and of the author given during his life-time.

S. M. Payne,
Hon. Secretary,
Institute of Psycho-Analysis.

II. *REPORTS OF PROCEEDINGS OF SOCIETIES*

It is not yet possible to publish complete sets of reports from the various branch Societies. These continue to arrive irregularly and often after a considerable lapse of time. The following have been received up to date.

THE TOPEKA PSYCHOANALYTIC SOCIETY

1941

September 27. Dr. S. Allen: 'Report on a Short Analysis of an Anxiety Hysteria.'

November 8. Dr. J. F. Brown (by invitation): 'A Critique of the Concept of Repression from the Standpoint of Field-Theory.'

December 6. Dr. R. P. Knight: 'The Psychoanalytic Treatment of a Case of War Neurosis.'

1942

January 31. Dr. M. Gitelson (Chicago, by invitation): 'Intellectuality and the Defense Transference.'

Febuary 28. Drs. E. Lewy and D. Rapaport: 'The Psychoanalytic Conception of Memory and its Relation to Recent Memory Theories.'

March 28. Dr. T. M. French (Chicago, by invitation): 'Ego Analysis as a Guide to Therapy.'

March 29. Dr. T. M. French (Chicago, by invitation): 'Physiological Inferences from Psychological Material.'

April 18. Dr. L. H. Bartemeier (Detroit, by invitation): 'Introduction to Psychotherapy.'

June 20. Dr. C. Tillman: 'The Psychoanalytic Study of a Military Reservist.'

September 26. Dr. K. A. Menninger: 'A Proposed Revision of the Theory of Sublimation.'

BRITISH PSYCHO-ANALYTICAL SOCIETY

1941

October 8. Dr. K. Friedlander: 'Children's Books and their Function in the Latency Period and Pre-puberty.'

October 22. Dr. E. Stengel: 'On a Certain Type of Air Raid Phobia.'

November 5. Discussion on 'The Psycho-Analytical Society and the Public,' opened by Miss B. Low.

November 19. Continuation of Discussion on 'The Psycho-Analytical Society and the Public.'

December 3. Dr. M. Schmideberg: '"Introjected Objects": A Terminological Issue or a Clinical Problem?'

December 17. Continuation of Discussion on 'The Psycho-Analytical Society and the Public.'

1942

January 21. Miss M. G. Evans: 'The Analysis of a Child's Drawings.'

February 4. Short Communications: (1) Mr. W. Schmideberg: 'The Original Sin.' (2) Dr. E. Glover: 'Intuition and Interpretation.'

February 18. Dr. M. Brierley: 'Some Notes on the Concept of "Internal Objects".'

March 4. Mrs. H. Hoffer: 'Œdipus Phantasies.'

March 18. Miss Anna Freud: 'Excerpts from an Annual Report on Work in a War-time Nursery.'

April 22. Continuation of Discussion on Miss A. Freud's paper, opened by Mrs. Burlingham with a report on the effect of evacuation on children.

May 6. Dr. M. Schmideberg: 'The Analysis of Delinquents.'

May 20. Dr. K. Friedlander: 'Preliminary Short Communication on Psycho-Analytical Approaches to the Problem of Delinquency.'

June 3. Dr. D. W. Winnicott: 'Report on Child Department Consultations.'

INDIAN PSYCHO-ANALYTICAL SOCIETY

1941

November 22. M. N. Banerji: 'Word Association Test as an Index of Personality.'

November 29. G. Bose: 'Some Points of Contact between Psycho-Analysis and the Hindu Doctrine of "Karma".'

December 13. H. P. Maiti: 'Stammering.'

December 20. S. C. Laha and N. N. Chatterji: 'Psycho-Analytical Observations of Psychotics during Histamin-Insulin Treatment.'

III. *REPORTS OF TRAINING ACTIVITIES*

CHICAGO PSYCHOANALYTIC SOCIETY

So far the only communication received on training matters is dated August 27, 1942.

Training Committee: Dr. F. Alexander, Dr. L. Blitzsten, Dr. T. M. French (Chairman), Dr. H. McLean, Dr. G. Mohr.

TOPEKA PSYCHOANALYTIC SOCIETY

(Under the auspices of the Chicago Institute for Psychoanalysis)

1941–1942

Seminars and Courses. Topeka: Dr. E. Lewy: Freud's Writings.—Dr. K. A. Menninger: Psychoanalytic Technique.—Dr. R. P. Knight: Theory of Dream Interpretation.—Dr. E. Lewy and Dr. M. O'Neil Hawkins: Application of Psychoanalysis to Non-Medical Problems. — *Didactic Seminars*:—Dr. R. P. Knight and Dr. E. Lewy: Clinical Conferences.—Dr. K. Menninger: Psychoanalytic Psychiatry.—*Los Angeles*: Dr. O. Fenichel: Psychoanalytic Theory of Neuroses.—Seminar on Questions of Psychoanalytic Technique (based on Glover's *An Investigation of the Technique of Psychoanalysis*).—Literature Seminar.—Dr. E. Simmel: Seminar on Freud's Clinical and Theoretical Papers on Neuroses and Psychoses.—Dr. E. Simmel and Dr. D. Brunswick, Mrs. M. Leonard, Mrs. C. Olden, Mrs. M. Munk: Educational Seminars: Introductory Lectures for Teachers.—Literature Seminar (Psychoanalysis Applied to Pedagogy).—Case Seminar for Advanced Teachers.—*San Francisco* (from December 12, 1941 to April 15, 1942): Dr. S. Bernfeld: Clinical Conferences.—Freud Seminar.

Training Committee: Dr. R. P. Knight, Dr. K. A. Menninger, Dr. E. Simmel.

Number of Candidates: In preparatory analysis: 11; of these, conducting case work under supervision: 5. Attending seminars: 11.

Dr. Ernest Lewy.

BRITISH PSYCHO-ANALYTICAL SOCIETY

1941–1942

Number of Candidates: On June 30, 1941, the total number of candidates on the Training List (in active training) was 18, of these 12 candidates were in analysis, 6 taking cases under control (one of whom was also in analysis), 11 attending seminars. During the year 2 candidates were newly admitted and 2 post-graduates were admitted for training in child analysis. Of the 7 candidates who had to suspend training the year before, one (Dr. Fajrajzen) resigned, 2 resumed training during the year, one had to suspend training owing to military service. One candidate (Dr. L. Simpson) resigned during the year. Three candidates were passed to treat cases under control, 1 to treat child cases under control. One candidate, Miss Elizabeth Schwarz, was passed for adult practice. Three candidates were passed for seminars.

June 30, 1942. Eighteen candidates are in active training (9 in analysis, 9 taking cases under control, 2 of whom are also in analysis, 10 attending seminars; 4 candidates are taking child cases under control). Seven candidates had to interrupt training owing to war conditions.

Lectures:

Spring Session: Six Lectures on Psychoses by Dr. Gillespie.

Seminars:

Spring Session: Six Seminars on Dreams by Miss Sharpe.

Summer Session: Weekly Technical Seminar by Mrs. Klein.

Autumn Session: Six Practical Seminars by Mr. Strachey.

October, 1941 to July, 1942: Weekly Technical Seminars by Miss Freud.

Three Single Practical Seminars were given by Dr. Glover.

Dr. Glover visited Manchester and conducted a Seminar for candidates and those interested in psycho-analysis working with Drs. Bálint and Gross. The extension of interest is progressing in this locality and further lectures are to be provided by the Training Committee next year.

Post-graduate training was provided for two doctors, from Vienna and the Argentine respectively.

Training Committee: Dr. M. Brierley, Miss A. Freud, Dr. E. Glover (Chairman), Mrs. M. Klein, Dr. S. M. Payne (Secretary), Dr. J. Rickman, Miss E. F. Sharpe, Mr. J. Strachey.

S. M. Payne.

INDIAN PSYCHO-ANALYTICAL SOCIETY

1941

Number of Candidates: 2.

Training and Control Analysts: Dr. G. Bose, Lt.-Col. O. Berkeley-Hill, Mr. M. N. Banerji, Mr. H. P. Maiti, Dr. E. G. Servadio, Mrs. Edith Ludowyk-Gyomroi. *Training Analysts:* Dr. S. C. Mitra, Mr. K. L. Shrimali.

Seminars and Courses: Dr. G. Bose conducted a weekly class for medical graduates and post-graduate students of Psychology, Calcutta University, where he discussed case histories and the technique of psycho-analysis.—Mr. H. P. Maiti: Popular lectures on the radio on Psycho-Analysis.

M. N. Banerji.

IV. *CLINIC REPORTS*

LONDON CLINIC OF PSYCHO-ANALYSIS

1941–1942

Consultations.

The total number of attendances at the Clinic consultations during the year was 96 (52 M., 44 F.) as compared with 63 the previous year and 81 the

year before. The notable increase in attendances since the end of March, 1942, is largely to be explained by a comparative stabilization of war conditions in London and in particular the cessation of the blitz. The male applicants for treatment are either over 40 or in reserved occupations or exempted from service owing to disability. This may account for the increase in cases of severe functional disturbance, which, in turn, increases the number of 'patients advised'. There is also an increase in applications from women who have returned from evacuation and taken up new work in London. The decrease in attendances during the winter months was again influenced by black-out difficulties. In this connection it may be noted, however, that patients under treatment attended regularly in spite of black-out and traffic difficulties in winter.

The 96 adult patients were dealt with as follows :

Advised at the time of examination	31 (19 M., 12 F.)
Recommended treatment	65 (33 M., 32 F.)
Of these latter :	
Offered Clinic vacancies	11 (6 M., 5 F.)
Offered private vacancies (at nominal fees)	9 (6 M., 3 F.)
Transferred to Temporary Psychological Aid Centre for treatment	3 (2 M., 1 F.)
	23 (14 M., 9 F.)
Put on the waiting list.	42 (19 M., 23 F.)

Diagnosis.

The following is the provisional diagnosis of the 65 who were recommended treatment ; it is subject to revision after treatment has begun.

Anxiety hysteria	16 (10 M., 6 F..)
Phobia	4 (1 M., 3 F)
Conversion plus anxiety hysteria	2 (– 2 F')
Hysteria	6 (1 M., 5 F')
Obsessional neurosis	4 (3 M., 1 F')
Mixed types	5 (4 M., 1 F.)
Depression	4 (2 M., 2 F.)
Character	2 (– 2 F.)
Enuresis	1 (1 M., –)
Frigidity	2 (– 2 F.)
Impotence	2 (2 M., –)
Homosexuality	4 (4 M., –)
Aggressiveness	1 (– 1 F.)
Hypochondria	1 (1 M., –)
Anxiety neurosis (? psychosis)	1 (– 1 F.)
Schizoid	5 (2 M., 3 F.)
Paranoid	2 (– 2 F.)
Transferred to Temporary Psychological Aid Centre :	
Anxiety states	3 (2 M., 1 F.)

Waiting List.

The number on the waiting list at the end of the year is 55 (28 M., 27 F.), as compared with 29 last year and 87 the year before. A number of cases on the waiting list wish to have their names kept on the list although they cannot at the moment undergo treatment in London. Although everything possible is done to avoid a longer waiting list than can possibly be dealt with, there has been a steady increase of patients waiting treatment who cannot be disposed of otherwise. Owing to the absence of many members in the Services and to the fact that other members have temporarily settled in the country, the placing of cases for treatment in the London area has become a problem.

Under Treatment.

There are at present 43 cases under treatment at the Clinic (17 M., 26 F.).

Child Department. Dr. Winnicott reports as follows :—

The present policy of the department is to supply children for analysis as required, and to deal with cases sent to the Institute for consultation, without however creating a waiting list. Eleven cases were needed for analysis and were supplied (6 boys, 5 girls). Eight of these were sent from Paddington Green Children's Hospital. In addition to these, 13 cases coming to the department were treated by other than psycho-analytic therapy. A report on these latter cases was read before the Society on June 3.

Diagnoses of cases referred for psycho-analysis :

Girl, aged 3, Character difficulties.
Girl, aged 3, Anxiety.
Girl, aged 3, Feeding inhibition, jealousy.
Girl, aged 3, Anxiety and feeding inhibition.
Girl, aged 3, Anxiety and feeding inhibition.
Boy, aged 7, Feeding inhibition.
Boy, aged 11, Manic-depressive character.
Boy, aged 3, Feeding inhibition.
Boy, aged 7, Schizophrenic regression.
Boy, aged 3, Reaction to parental split.
Boy, aged 8, Character difficulties.

E. Glover.

INDIAN PSYCHO-ANALYTICAL SOCIETY

Lumbini Park Mental Hospital

1941

The following extracts are taken from the report on the above hospital.

Consultations.

The total number of attendances at the mental out-patient clinic during the year was 399.

The total number of mental patients receiving out-patient treatment during the year was 101, during the previous year 74. Most, if not all, of the mental cases who have attended the outdoor clinic for treatment come from Calcutta and its suburbs and some of them from the mofussil. The following

are the types of mental cases that have received treatment in the outdoor clinic during the last two years :—

Anxiety hysteria	2
Anxiety neurosis	10
Conversion hysteria	5
Dementia præcox	26
Depression	8
Drink habit	1
Drug habit	1
Epilepsy	8
Epileptoid state	1
Fugue	2
Mania	2
Manic-depressive psychosis	1
Mental deficiency	20
Normal	1
Obsessional psycho-neurosis	7
Paralysis agitans	1
Paranoia	64
Paraphrenia	1
Problem child	1
Psycho-neurotic symptoms	9
Stammering	2
Undiagnosed	2

The report from which these figures are drawn states that every known scientific method of approach to improve the condition of a mental patient is adopted. As far as can be gathered from the report only the psycho-neurotic cases were treated by psycho-analysis. This refers of course to the out-patient department. Of 25 cases admitted for in-patient treatment 2 were psycho-neurotic, the diagnosis of the other 23 cases was :—

Dementia præcox	8
Drink habit	1
Fugue	1
Mania	2
Manic-depressive psychosis	1
Mental deficiency with psychotic symptoms	1
Paranoia	20
Paraphrenia	1
Psycho-neurotic symptoms	2

S. C. Laha.

V.

SAN FRANCISCO PSYCHOANALYTIC SOCIETY

A notification has been received announcing the formation of a San Francisco Psychoanalytic Society. We have not yet received a full list of members but understand that the following are included in that list :—

Dr. Bernhard Berliner.
Dr. Otto Fenichel.
Dr. George Gerö.
Dr. Joachim Haenel.
Dr. Bernard A. Kamm.
Dr. Jacob Kasanin.
Dr. Douglass W. Orr.
Dr. May Romm.
Dr. Ernst Simmel.
Dr. Charles W. Tidd.
Dr. Carl Tillman.
Dr. Emanuel Windholz.
Dr. Siegfried Bernfeld (Hon. Member).

The foregoing were previously members of the Topeka Psychoanalytic Society and changes of their addresses will be found under that heading in this issue.

MELBOURNE INSTITUTE FOR PSYCHOANALYSIS

The following excerpts are taken from the first Annual Report of the Melbourne Institute for Psychoanalysis.

The foundation of this Institute was made possible by the generous donation of Miss Lorna Traill, Melbourne. But its existence is no less due to the efforts of Dr. Paul G. Dane, Dr. R. Ellery, Dr. N. A. Albiston, Dr. A. R. Phillips and Dr. P. G. Reynolds. Dr. Ernest Jones has accepted membership of the Board of Directors. The Institute is incorporated and licensed as an Association under the Companies Act. It is administered and supervised by a Council of Directors, whose members are Dr. P. G. Dane (Chairman), Dr. R. Ellery (Hon. Secretary), Dr. E. Jones (London), Dr. N. A. Albiston, Dr. A. R. Phillips, Dr. P. G. Reynolds, Dr. L. C. Winn (Sydney). Dr. Clara Lazar-Geroe is employed as psycho-analyst.

The Institute was opened on October 11, 1940, by Judge Foster. Dr. Dane outlined our programme, and Dr. Winn addressed the meeting in the name of the British Psycho-Analytical Society.

The working scheme of the Institute was :

(1) to start a psycho-analytical clinic (*a*) for adult patients, (*b*) for children (this acting also in an advisory capacity for pedagogues and parents),

(2) to deliver lectures and build up study circles,

(3) to build up a psycho-analytical library.

Our clinical work started on January 15, 1941. There are 2 working rooms, 1 office (nurse's room) and 1 large waiting room, which serves also as lecture room.

Clinic

Every patient who comes to our clinic undergoes a physical examination by one of the members of our Board.

We have been consulted by 29 adult patients, of whom there have been

Hysteria	3
Perversions	6
Stealing	1
Obsessional neurosis	4
Various anxiety states	10
Agoraphobia	2
Depression	2
Character neurosis	1

Of these patients 3 are in regular analytic

treatment, 2 of them having 5 hours weekly, 1 patient having 4 hours weekly. Lacking the necessary time for regular analyses, we had to take 6 more cases for treatment with one or two sessions weekly, with the intention of settling actual problems, 3 of these cases have improved and were discharged after 20, 10 and 6 sessions respectively.

The Children's Clinic started work in May, 1941. A great number of difficulties had to be overcome and during the first year no opportunity existed of actually analysing children.

Lectures and Courses

The Institute arranged the following courses :

(1) Dr. Dane : Introductory Lectures on ' Psycho-Analysis and Mental Disorders.' (3) Dr. Lazar-Geroe : ' Technique of Psycho-Analysis.' This course was held in April and May, 1941, for medical students. Attendances : 5.

(2) Dr. Lazar-Geroe : ' Introductory Lectures on Psycho-Analytical Pedagogics ' (8). Attendances : 18.

Psycho-Analytical Lectures at other Institutions

(1) Dr. Dane : ' Educational Problems ', address given at the Girls' Grammar School, ' Fintona ' for parents, July, 1941.

(2) Dr. Lazar-Geroe : ' Influences of the New Psychological Schools on Pre-school Education ', 4 lectures in August-September, 1941. These lectures were arranged for third year students of the Teachers' Training College of the Free Kindergarten Union of Victoria, in their subject in ' Mental Hygiene '.

(3) Dr. Lazar-Geroe : ' Psycho-Analytical Approach to Juvenile Delinquency ', 3 evenings with the Study Circle of the Children's Court Probation Officers. Problems were discussed in case studies given by Probation Officers. Attendances : 12–15.

(4) During the winter the Institute arranged some discussion evenings, inviting a group of psychiatrists. ' Perversions.' Dr. Ellery presented several case histories. ' Juvenile Delinquency.' Dr. A. Muhl gave the case study and therapy of a delinquent boy. Discussion : the rôle of social help (outer world) and that of psycho-analysis with delinquent children. ' Child Analysis '. Dr. Lazar-Geroe presented the analysis of a girl of 6 with obsessional symptoms. Attendances : 8–9.

Library

Dr. P. G. Dane presented the Institute with the whole of his collection of psycho-analytical works, thus laying the foundation of our library, with about 100 volumes. Since then about 25 volumes have been added, donated by Mr. N. G. Jarvey. Three volumes were bought.

C. Lazar-Geroe.

VI. *CHANGES OF MEMBERSHIPS*

During the past year no notification of addresses has been received from the following Societies :

Danish - Norwegian Psycho - Analytical Society

Dutch Psycho-Analytical Society

Finnish-Swedish Psycho-Analytical Society

French Psycho-Analytical Society

Hungarian Psycho-Analytical Society

Swiss Psycho-Analytical Society

Tokyo Psycho-Analytical Society

Readers are therefore again referred to Vol. XX, Parts 3 and 4, and Vol. XXI, Part 4, of this Journal for the last official lists of these Societies. As regards those branches with which we still retain contact, we have received lists of members' addresses only from the following :

Topeka Psychoanalytic Society

Washington - Baltimore Psychoanalytic Society

British Psycho-Analytical Society

Indian Psycho-Analytical Society

The list of changes given here is therefore official only in respect of these four Societies. For the convenience of readers, however, we have noted a number of changes in other Societies which we have good reason to believe are accurate. This list is naturally incomplete.

THE AMERICAN PSYCHOANALYTIC ASSOCIATION

Boston Psychoanalytic Society

Honorary Member

Cobb, Dr. Stanley, Massachusetts General Hospital.

Members

Alexander, Dr. George H., Butler Hospital, Providence, R.I.

Deutsch, Dr. Felix, 82 Marlborough Street.

Helgesson, Dr. Uno, 2 Maple Street, Springfield, Mass.

Howard, Dr. Paul, McLean Hospital, Waverley, Mass.

Lindemann, Dr. Erich, Massachusetts General Hospital.

Ludwig, Dr. Alfred, 66 Commonwealth Avenue.

Taylor, Dr. John H., 37 Marlborough Street.

Change of Address

Anthonisen, Dr. Niels L., 88 Linden Street, Brattleboro, Vt.

Barrett, Dr. William G., 450 Sutter Street, San Francisco, California.

Dawes, Dr. Lydia, 259 Beacon Street.

Jackson, Dr. Edith B., LMP Building, No. 4085, 789 Howard Street, New Haven, Conn.

Karpe, Dr. Richard, 13 Belmont Avenue, Northampton, Mass.

Michaels, Dr. Joseph J., 82 Marlborough Street.

Putnam, Dr. Marian C., 37 Marlborough Street.

Waelder, Dr. Robert, Hotel Warburton, Philadelphia, Pa.

Young, Dr. David, 540 East 1st South, Salt Lake City, Utah.

Chicago Psychoanalytic Society

Member

Van der Heide, Dr. Carel, 43 East Ohio Street.

Associate Member

Gitelson, Dr. Maxwell, Michael Reese Hospital, 29th Street and Ellis Avenue.

Change of Address

Weiss, Dr. Edward, 43 East Ohio Street.

Change of Office

Eisler, Dr. Edwin R., 43 East Ohio Street (*President*).
Gerard, Dr. Margaret, 43 East Ohio Street (*Vice-President*).
Wilson, Dr. George W., 30 North Michigan Avenue (*Secretary-Treasurer*).

Detroit Psychoanalytic Society

Member

Redl, Dr. Fritz, 17673 Manderson Street, Apt. 102.

New York Psychoanalytic Society

Members

Bergler, Dr. Edmund, 251 Central Park West.
Davison, Dr. Charles, 1155 Park Avenue.
Feldmann, Dr. Sandor, 292 Oxford Street, Rochester, N.Y.
Frumkes, Dr. George, 70 East 96th Street.
Glauber, Dr. I. P., 111 East 60th Street.
Goolker, Dr. P., 100 East 94th Street.
Huschka, Dr. Mabel, 410 East 57th Street.
Jacobson, Dr. Edith, 50 West 96th Street.
Kronold, Dr. Edward, 17 East 96th Street.
Lowenfeld, Dr. Henry, 168 West 86th Street.
Needles, Dr. William, 70 East 83rd Street.
Schatner, Dr. Marcus, 1133 Park Avenue.
Stone, Dr. Leo, 471 Park Avenue.

Change of Address

Loveland, Dr. Ruth, 133 East 58th Street.
Mahler-Schoenberger, Dr. Margaret, 350 Central Park West.
Mittelmann, Dr. Bela, 570 Park Avenue.
Oberndorf, Dr. C. P., 40 Central Park South.
Slutsky, Dr. Albert, 590 West End Avenue.
Sperling, Dr. Otto, 115 Eastern Parkway, Brooklyn, N.Y.
Stoloff, Dr. Emile Gordon, 225 East 74th Street.
Van Ophuijsen, Dr. J. H. W., 130 East 67th Street.
Warburg, Dr. Bettina, 130 East 67th Street.
Weinstock, Dr. Harry I., 941 Park Avenue.

Philadelphia Psychoanalytic Society

Change of Office

English, Dr. O. Spurgeon, 255 South 17th Street (*President*).
Pearson, Dr. Gerald H. J., 111 North 49th Street. (*Vice-President*).

Topeka Psychoanalytic Society

Members

Geleerd, Dr. Elizabeth R., The Menninger Clinic, Topeka, Kan.
Gerö, Dr. George, Maple Boulevard, Route 4, Box 634, Tucson, Arizona.
Tillman, Dr. Carl, The Menninger Clinic, Topeka, Kan.

Resignation

Campbell, Dr. Coyne H.

Correction of last Membership List

The following were included in the membership list by mistake:
Benjamin, Dr. Anna.
Robbins, Dr. Lewis.

Change of Address

Fenichel, Dr. Otto, 582 North Wilcox Avenue, Los Angeles, Cal.
Galbraith, Dr. Hugh M., 652 First National Building, Oklahoma City, Okla.
Hawkins, Dr. Mary O'Neil, The Menninger Clinic, Topeka, Kan.
Kamm, Dr. Bernard A., 43 East Ohio Street, Chicago, Ill.
Orr, Dr. Douglass W., 501 Medical and Dental Building, Seattle, Washington.
Windholz, Dr. Emanuel, 2686 Union Street, San Francisco, Cal.

Change of Office

Allen, Dr. Sylvia, The Menninger Clinic, Topeka, Kan. (*Secretary-Treasurer*).
Harrington, Dr. G. Leonard, Professional Building, Kansas City, Mos. (*Vice-President*).
Lewy, Dr. Ernest, The Menninger Clinic, Topeka, Kan. (*President*).

Washington-Baltimore Psychoanalytic Society

Honorary Member

Thompson, Dr. Clara, 151 East 83rd Street, New York City.

Member

Halperin, Dr. Alexander, 1028 Connecticut Avenue, Washington, D.C.

Change of Address

Colomb, Dr. Anna C. D., East Louisiana State Hospital, Jackson, Louisiana.
Lewis, Dr. Nolan D. C., N.Y. State Psychiatric Institute and Hospital, 722 West 168th Street, New York City.
Reede, Dr. Edward Hiram, 1029 Vermont Avenue, N.W., Washington, D.C.
Weininger, Dr. Benjamin I., 1028 Connecticut Avenue, Washington, D.C.

Change of Office

Crowley, Dr. Ralph, 1650 Harvard, N.W., Washington, D.C. (*Secretary-Treasurer*).

Hadley, Dr. Ernest E., 1835 Eye Street, N.W., Washington, D.C. (*President*).
Weigert, Dr. Edith, 12 Oxford Street, Chevy Chase, Md. (*Vice-President*).

BRITISH PSYCHO-ANALYTICAL SOCIETY

Member

Macdonald, Dr. R. A., 39 Clifton Hill, N.W.8

Associate Members

Fleischer-Gerö, Mrs. Elisabeth, 11 Compayne Gardens, N.W.6.
Frank, Dr. Klara, 2B, Winchester Road, N.W.3.
Usher, Dr. Ruth D., 5 (I) Bickenhall Mansions, W.1.

Change of Address

Fairbairn, Dr. W. R. D., 21 Grosvenor Crescent, Edinburgh 12.
Kris, Ernst, 135 Central Park West, New York City.
Kris, Dr. Marianne, 135 Central Park West, New York City.
Maas, Dr. Hilde, 31 Hanover Gate Mansion, Park Road, N.W.1.
Matthew, Dr. David, 5 Suffolk Road, Edinburgh 9.
Ruben, Mrs. Margarete, Elm Tree House, 13 Netherhall Gardens, N.W.3.
Schwarz, Miss Elisabeth, 18 Farndon Road, Oxford.
Scott, Dr. W. Clifford M., Whitchurch Emergency Hospital, Cardiff.
Sheehan-Dare, Miss Helen, 3 Victoria Park Road, Exeter.
t engel, Dr. Erwin, 61 Morningside Park, Edinburgh 10.
Stephen, Major A. L., R.A.M.C., 46 Craigmillar Park, Edinburgh 9.
Stephen, Dr. Karin, Shenley Mental Hospital, Shenley, Herts.
Stoddart, Dr. W. H. B., 35 Harley Street, W.1.
Taylor, Dr. J. M., 44 Queen Anne Street, W.1.
Thomas, Dr. Rees, c/o Board of Control, Clifton Hotel, St. Anne's-on-Sea, Lancs.
Witt, Dr. Gerhard, 200 West 15th Street, New York City.
Yates, Dr. Sybille L., Netherne Hospital, Coulsdon, Surrey.

Change of Office

Friedlander, Dr. Kate, 2 Harley House, Upper Harley Street, N.W.1 (*Acting Treasurer*).
Payne, Dr. Sylvia M., 11 Devonshire Place, W.1. (*Business Secretary, Training Secretary*).

INDIAN PSYCHO-ANALYTICAL SOCIETY

Honorary Member

Singhi, Bahadur Singh, 48 Gariahat Road, Calcutta.

Associate Members

Ahmed, M. U., Krishnagar College, Nadia.
Banerji, Samiram, 9/2 Palit Street, Calcutta.
Bose, Susanta Kumar, 29 Circular Road, Ranchi.
Chakravarti, Bholanath, 15D Rajendralala Street, Calcutta.
Chatterji, Negendra Nath, 128 Bediadanga Road, Tiljala, 24 Parganas.
Desai, Bhupendra, 95 Chittaranjan Avenue, Calcutta.
Ghosh, Sachindra Prosad, 1 Bhabanath Sen Street, Calcutta.
Guha, Biraja Sankar, 4 Federation Street, Calcutta.
Gupta, Kailash Pati, 39 Tarak Paramaniok Road, Calcutta.
Hakonsson, Tore, 1 Buddhist Temple Street, Calcutta.
Pai, T. R. A., Canara Mutual Assurance Co. Ltd., Udipi.
Sarma, Indira Kanta, 26 Raja Basanta Roy Road, Calcutta.
Shah, Rasiklal B., Santiniketan, Bolpur.

Resignations

Agarwalla, D.
Bose, Nirmal Gobinda.
Bose, S. K.
Chatterji, A. C.
Chatterji, C. K.
De, S. C.
Franklin, E. W.
Ghosh, B. B.
Ghosh, Dr. R.
Moitra, J. N.
Moitra, S. N.
Mukdum, M. M.
Sengupta, Capt. P. K.
Sinha, Bimalendu.
Sinha, S.

Change of Address

Berkeley-Hill, Lt.-Col. O., Ranchi Nursing Home, Station Road, Ranchi.
Bora, G., 5 Royal Exchange Place, Calcutta.
Chatterji, B. B., 82 Dr. Sures Sarkar Road, Calcutta.
De, R. K., Imperial Bank of India, Muzaffarpur.
De, Ranajit Kumar, 17 Ramakanta Sen Lane, Utadanga, Calcutta.
Ganguli, M., 8/1 Dover Lane, Calcutta.
Ghosh, B. C., 3 Robinson Street, Calcutta.
Halder, R. C., Kadamkuan P.O. (Patna).
Laha, S. C. 128 Bediadanga Road, Tiljala, 24 Parganas.
Ludowyk-Gyomroi, Mrs. Edith, Nawinna, Nugegoda, Ceylon.
Mathews, Bernard, 7 Wellesley Place, Calcutta.
Mukerji, A. N., 8B, Shib Sankar Mallick Lane, Calcutta.
Sen, J. M., Krishnagar College, Nadia.
Sinha, T. C., 32 South End Park, Ballygunge, Calcutta.

VII. *OBITUARY*

Haenel, Dr. Irene, Los Angeles, California, U.S.A. (*Topeka Member*).
Staub, Dr. Hugo, Santa Barbara, California, U.S.A. (*British Member*).
Steiner, Dr. Maxim, London.

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